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ABSTRACT

This report evaluates a three-year-demonstration program in child advocacy, created as part of existing Head Start Parent-Child Centers to meet the needs of children under 5 and their families. Local services were integrated and new services created in a variety of areas (health, housing, education and welfare) using a primarily paraprofessional untrained staff. Evaluation data were collected from on-site interviews with Advocacy Component (AC) coordinators and staff members, community agency administrators, and randomly selected families served by the ACs as well as from monthly statistical reports on contacts, referrals, staff changes, etc. The report is divided into eight sections (1) the history and development of the AC program; (2) initial objectives and their changes; (3) activities on behalf of individual families and the relationships between ACs and the families served (including AC population characteristics); (4) family education efforts (e.g., workshops, meetings); (5) agency coordination efforts; (6) staffing patterns, staff functions, training and turnover; (7) the functional cost data analysis; and (8) conclusions. Generally, the ACs are thought to have accomplished considerable work in their communities and on behalf of individual families, but their achievements were found to fall short of the nine national goals originally set for the program. (ED)

THE ADVOCACY COMPONENTS OF SIX HEAD START PARENT-CHILD CENTERS:

A FINAL REPORT

Prepared for
Office of Child Development
Department of Health, Education, and Welfare

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EXECUTIVE SUMMARY

This study report deals with the three year demonstration program in child advocacy funded by the Office of Child Development (OCD). These demonstration (initially seven, later reduced to six) Advocacy Components (ACs) were created as part of existing Head Start Parent-Child Centers (PCCs). The goal of these ACs was to meet the needs of children in the catchment area from birth to five years, and the needs of their families, through local service integration, and if necessary, the creation of new services.

The Advocacy Components (ACs) were designed to provide referral, but not direct, services to low-income families not already served by the PCCs. The ACs were to assess the needs of each family in a door-to-door outreach effort and to meet unmet needs through referrals to existing agencies, and to follow-up the families and agencies. In order to effect these referrals, the ACs were to identify all existing resources and services. Where gaps in resources were identified, the ACs were to work to promote greater sensitivity to the needs of low-income people among existing resources, as well as coordination among agencies. The central ~~organizing~~ concept was that the ACs would teach families to become advocates on their own and on their children's behalf.

Each of the projects was staffed with from one to three professionals in administrative, and supervisory

roles, and with four to seven paraprofessionals in outreach roles. In addition, all of the ACs had secretarial and clerical staff, and several ACs had additional professional staff (i.e., nurse, nutritionist) or additional paraprofessional staff (i.e., transportation aides).

The successes and failures of the ACs which are detailed in the report are summarized below. As will become evident in reading this report, it is difficult to assess the "success" of this program because criteria of success usually reflect achievement relative to a set of specified objectives; the objectives in this case proved to be quite unrealistic. In an extremely limited period of time, the ACs were expected to pursue both case and class advocacy goals, using a primarily paraprofessional untrained staff. In other words, they were expected both to assess needs and to make referrals on behalf of individual families, and to advocate ~~for~~ changes and new services in large public agencies in a variety of areas: health, housing, education, and welfare. The ACs accomplished considerable work in their communities and on behalf of individual families, but their achievements fell far short of the national goals.

Hence, measured against the national goals, the advocacy program is in large part a failure, but the unrealistic nature of these goals and of many of the local objectives makes this an inadequate standard against which to measure achievement. The following summary is presented according to each of the national goals.

National Goal #1: To identify the unmet needs of low-income families with children 0-5 years in a designated catchment area.

During the course of the program, 3,927 needs assessments were completed. The program demonstrated that an outreach capability is important in that the needs of many underserviced families are identified and defined through such activity. Through the process of identification, consciousness is raised in the family as to the need to "do something" and to overcome feelings of passivity and resignation. Thus, the needs assessment can be regarded as a useful tool not only for identifying needs, but for mobilizing families, and for building relationships of trust, as well.

National Goal #2: To identify all private and public programs (local, state, and federally-supported) that provide services for residents in the catchment area, and to compile information on existing community services.

Resource directories were compiled by four Components and all of the ACs were highly successful in terms of identifying community resources and services. Identification of existing resources went far beyond mere identification, to include a thorough knowledge of services available, and when, eligibility requirements, and staff functions within each agency. This process of identification and of creating a systematic information and referral system can be expected to take a professional approximately one full year.

National Goal #3: To identify the gaps between needs and existing services.

All of the ACs identified gaps in services through information collected regarding family resources. This information enabled AC staff to pinpoint gaps, inadequacies, and insensitivities in available services. Systematic documentation of gaps was undertaken in a number of specific instances, detailed in this report.

National Goal #4: To promote the development of comm ty resources which will fill gaps in existing services.

"Promoting the development of community resources ..." turned out to be very difficult. State and federally-supported resources are usually unable to initiate new programs, or to hire new staff in response to needs identified at the local level. In many instances, agency staff are aware of needed services, but lack the money or authority necessary for their implementation. Hence, while some new services were promoted to fill gaps, with few exceptions this is not an area met by outstanding results.

National Goal #5: To assist in bringing together a comprehensive and efficient delivery system of services.

This goal also proved difficult to achieve. In retrospect it was unrealistic to expect that a small agency, such as the PCC/AC, could integrate and coordinate the services of mammoth and long-established agencies such as a Department

of Social Services, a large public hospital, or a public housing department. While some examples of service coordination are cited in the report, it cannot be said that the ACs succeeded in bringing together comprehensive and efficient delivery systems in their communities.

National Goal #6: To assist families by referring them to specific agencies and follow through to ensure that the services are provided.

Five thousand six hundred and seventy-five referrals were made on behalf of AC families. While there is no question that many families received assistance through AC-initiated referrals, the mean number of referrals (1.28) per family is relatively small, and the situation of most families has changed only minimally. This is because many of the most serious needs, i.e., housing and employment, cannot be met through referrals, and because it often takes much time and effort to effect even a single referral. Families in the target areas tend to seek help only in response to a crisis. Thus, they are extremely difficult to motivate when it comes to preventive health services, e.g., check-ups, immunizations, enrollment for coverage.

National Goal #7: To develop a training program for child advocates in concert with local colleges and other agencies.

With very few exceptions, the ACs were not able to develop a training program for child advocates. In fact, they had enough difficulty training their own staff and conducting the

day-to-day work of advocacy. While a few agencies were persuaded to take on some advocacy functions, no training program in terms of an exportable curriculum was developed. In retrospect, it was unrealistic to think that the Components would be able to do any more than provide training for their own staffs, which in most cases represented a major effort.

National Goal #8: To ensure the delivery of adequate services to expectant mothers and their newborn babies.

Six hundred and seventy-two pregnant women were identified, however, the majority of those identified were receiving adequate pre-natal care as defined by the semester of pregnancy in which medical attention was sought and the frequency of visits. Efforts to create pre-natal classes or to increase the level or quality of pre-natal care met with little success.

National Goal #9: To identify high-risk mothers and children so that necessary medical, nutritional, and other needed services can be available to them.

Two hundred and fifty-six high-risk mothers were identified but in most instances they were not given preferential treatment because the entire population served by advocacy was considered to be in great need. On the whole, the families served by the ACs would be characterized by social service agencies as the most needy multi-problem families in the community.

In conclusion, it can be stated that the ACs did not "work themselves out of a job," as had been hoped initially.

The majority of families did not learn to become their own advocates, and the majority of agencies did not learn to work together in an efficient coordinated effort, and were not able to adapt advocacy functions. However, the ACs were of great assistance to some families, and they demonstrated the usefulness of certain aspects of the advocacy approach to other agencies, i.e., outreach, family group education efforts, and client advocacy. Perhaps as important, the advocacy demonstration laid an informational base, which should be applied to any future efforts in this general service area.

CHAPTER I

INTRODUCTION

1.0 INTRODUCTION

The Child Advocacy Components of the Parent-Child Center (PCC) program completed 36 months of planning and operation on October 31, 1974. This report is the fourth in a series by the Center for Community Research (CCR) which includes a report on the program at inception, a volume of six-month case studies and a report of the start-up year. It is designed to present both an overall view of the program and specific data on program statistics and costs during the period of October, 1973, through July, 1974, inclusive.

The Child Advocacy program was developed as a Component of the Parent-Child Center (PCC) program, in order to expand the potential of the PCCs. The limitations of the PCC program are stated in a memorandum dated April 4, 1971, from the Director of the Office of Child Development (OCD) Dr. Edward Ziegler, to the Secretary of Health, Education, and Welfare:

1. Children enter the program after the period of gestation and delivery, sometimes without the benefit of adequate pre-natal and newborn care.
2. Children leave the program at age 3, in some areas without the benefit of appropriate continuing attention.
3. Older siblings are excluded as the primary objects of concern, and are benefitted only because of the need for total family development and parent participation.
4. In many areas, there is an absence or deficiency of the necessary supportive structures for child and family development (medical, social, educational).

5. PCCs serve only a very limited number of children and families in need, and community impact is, thus, diluted.

The Child Advocacy concept received considerable attention during the 1970 White House Conference on Children. During this conference, it was emphasized that both parents and child-serving agencies often fail to meet the needs of children for two reasons: lack of resources, and lack of knowledge. Reflecting this emphasis, the role of Child Advocate was defined: an individual who, acting on behalf of children, would help them to meet their basic needs. A model program, the Advocacy Component of the Parent-Child Center was designed to meet the needs of children from birth to five years, and those of their families, through local service integration and, where necessary, through the creation of new services. As a means to achieving those ends, several steps were envisaged. The needs of each family were to be assessed through survey procedures. Family needs were to be met by educating community residents in the use of existing services, by helping toward the better integration of existing services and, if necessary, by advocating for and assisting in the creation of new services.

By October, 1971, seven of the 33 PCCs had been selected by OCD staff as sites for Advocacy Components (ACs), to serve as a demonstration of the Advocacy concept and how it might develop as a part of the PCC program. The seven PCC/ACs were located in rather differing communities. Three were in rural

areas: the La Junta, Colorado AC served Mexican-American families primarily; the Leitchfield, Kentucky and Huntington, West Virginia Components served Caucasian families primarily. The four urban Components: Baltimore, Maryland; Cleveland, Ohio; Boston, Massachusetts; and Jacksonville, Florida all served predominantly Black populations. Two urban Components defined public housing projects as their target area, the other two served the entire areas surrounding the projects. In the rural communities, and in Jacksonville, there was a scarcity of resources available to the target population. In the remaining three urban communities, there were extensive resources, but these tended to be, at the time of program inception, unresponsive to the needs of the community and were therefore under-used by the target group.

During the course of the CCR study, several significant changes in program occurred. In February, 1973, the Component staffs were told that their funding would probably be discontinued as of October of that year. While termination did not occur at that time, the effects of this "rumor" were felt in all facets of AC activities: staff morale was very low, some staff members made plans to find other employment, the number of contacts with agencies was less than usual for the months following the "news," and the frequency of home visits to and referrals on behalf of families was lower than normal. In Spring, 1973, the La Junta PCC/AC changed its grantee and subsequently lost its Advocacy Component. Accordingly, most

data presented in this report reflect the activities of six (rather than seven) Components.

In May, 1974, just prior to the last CCR site visit, Component staffs were formally notified that financial support would be terminated effective October 31, 1974. This formal announcement had further negative effects on morale, planning activities, and commitment to program. In retrospect, it is clear that the short-term, uncertain nature of project funding had a profound effect on staff stability and morale, and on the formulation and implementation of Component objectives.

2.0 THE EVALUATION: METHODS OF PROCEDURE

2.1 On-site interviewing

CCR staff conducted a total of five site visits at each Component, the first of which occurred between April 15 and May 19, 1972, shortly after program inception (T1). At this time, interviews were conducted with AC Coordinators, with each AC staff member, with four or five agency administrators in each community, and with 25 randomly selected AC families from each Component. One year later interviews were conducted with the same complement of respondents (T4). In the interim, interviews designed to update information on relationships with families and agencies, the ongoing process of staff training, and the overall style and functioning of each AC, were conducted in September, 1972 (T2) and in February, 1973 (T3). A more complete description of the methods of procedure used for these interviews and a detailing

of the data collected is to be found in the CCR report of July, 1973, The Advocacy Components of Seven Parent-Child Centers: A Final Report of the Start-Up Year.

During the second year of the CCR study, the bulk of information was collected through the Monthly Monitoring System and only one site visit (T5) was made to each Component. These final site visits were conducted during May and June, 1974. At this time the AC Coordinators were interviewed extensively on all aspects of Component activities, a group interview was conducted with the majority of AC staff members, and from four to six agency interviews were conducted. Whereas efforts had been made to conduct T2 interviews with the same agencies that had been seen at T1, the procedure followed for these final interviews was somewhat different. As several Components had begun work on special inter-agency projects during the second program year, Coordinators were asked to arrange CCR interviews with those agencies with which they had developed the closest relationships, trying, wherever possible, to retain at least two of the original T1 or T2 agencies for re-interview. At no Component was the sample of agencies composed entirely of "new" agencies. These interviews were conducted at each respective agency with either the head of the relevant service, or with a senior staff delegate of that person.

2.2 Monthly Monitoring System

The CCR Monthly Monitoring System was initially installed

in May, 1972. Fully operational in approximately two months, the System was designed to collect the following kinds of data on a per month basis:

- number of telephone calls made to AC families
- number of home visits
- number of new contacts
- number of families terminating from AC
- number of referrals by problem area and outcome
- cumulative statistics in specific referral areas (Supplementary Monitoring Forms)

Each family assessed by the Components was assigned an identification number which was used in all reports to CCR. Every time a specific action was taken by the AC on behalf of a family, the family's ID number and the action taken were reported on the appropriate forms. In this way, an ongoing record of Component activities was compiled and analyzed in terms both of individual families and of aggregates of families, by particular actions and service areas. These data were supplemented by the information obtained from AC staff during site visits.

Based on the first year's experience with the System, and after consultation with National Office Staff, and review of their need for cost data, the reporting forms were revised

to be more comprehensive. CCR staff made only one visit to each Component during the second year. While it was important to precisely document the start-up process through monitoring and on-site interviewing, once the patterns of operation had been set, this expensive form of documentation was no longer necessary. To this end, the Monthly Monitoring System was expanded to include information previously collected on site:

- staff: training, termination and hiring of new staff
- family group activities: types of events, attendance, amount of staff time required for preparation
- agency contacts: agencies identified, new linkages formed, inter-agency meetings, changes in service delivery

and information not collected by CCR staff prior to this revision:

- staff time: allocation of staff time by functional area
- Component costs: allocation of monthly line budget item costs by functional area

In addition, the Referral Reporting Forms were revised in an effort to reduce reporting time. As with the System used during the first year, frequent telephone contact between Coordinators and CCR staff was maintained.

As the System did not represent an entirely new requirement for the ACs, a training conference was not convened. Instead, CCR staff compiled a comprehensive manual for use and distributed two copies to each Component. The month of October, 1973, the first month in which the new System was used, was set aside as a trial period. As the forms were received from each Component they were carefully examined and coded by CCR staff members. Follow-up on errors, inconsistencies or misunderstandings was accomplished by telephone calls preceded by explanatory letters. While some Components continued to have difficulties with particular sections of the Forms, the System was fully operational by November. At the end of November, and in each succeeding month, CCR fed back the following kinds of data to each Component:

- the number of referrals effected during the month
- the type and outcome of each referral
- the person (e.g., child, parent, etc.) referred
- the number of different families referred
- the dollar amount and percentage of money expended on line budget items by functional service categories (CCR computed the data on personnel costs on the basis of Component annual budgets and the AC staff time allocation forms submitted monthly)

Similar information on all Components was forwarded to the National Office.

3.0 ORGANIZATION OF THIS REPORT

The first task for the Advocacy Components was to develop specific program objectives with the consultation of, and within a framework provided by, the Office of Child Development. From the time of this initial definitional activity, throughout the life of the program, CCR has followed the development of program objectives. Chapter II of this report is devoted to objectives, and to a description of what they were initially, and how and why they changed.

Subsequent to the development of objectives, ACs focused on needs assessments, developing relationships, making referrals on behalf of families, and on developing a core of knowledge and establishing relationships with families. A discussion of what was done for families is the subject of Chapter III.

Following an initial period devoted to the assessment of needs and to the establishment of relationships with families, a number of Components began implicitly or explicitly to work toward the goal of educating families to the need for, and use of services. Attempts to organize educational workshops, mass meetings, and ongoing groups are detailed in Chapter IV.

The processes of identifying community resources, of developing a core of knowledge about services offered, of

understanding eligibility requirements and staff responsibilities, and of building collaborative relationships with other agencies are detailed in Chapter V.

Chapter VI of the report focuses on the AC staffs. Staffing patterns, turnover, staff responsibilities, and staff training are described.

Chapter VII presents an analysis of functional cost data collected from the Components during the final project year.

CHAPTER II

OBJECTIVES

The material presented in this chapter provides an overview of the projects' growth and activities within the framework of the national OCD goals. More detailed descriptions of these goal-specific activities are to be found in the rest of this report.

The information presented in this chapter derives from the following sources:

- site visit interviews with AC Coordinators
- Monthly Monitoring Reporting data
- ongoing telephone contact with Components' staffs

1.0 INTRODUCTION

The national goals of the Child Advocacy Components were as follows:

- National Goal #1: To identify the unmet needs of low-income families with children 0-5 years in a designated catchment area.
- National Goal #2: To identify all private and public programs (local, state and federally-supported) that provide services for residents in the catchment area, and to compile information on existing community services.
- National Goal #3: To identify the gaps between needs and existing services.
- National Goal #4: To promote the development of community resources which will fill gaps in existing services.
- National Goal #5: To assist in bringing together a comprehensive and efficient delivery system of services.

- National Goal #6: To assist families by referring them to specific agencies and follow through to ensure that the services are provided.
- National Goal #7: To develop a training program for child advocates in concert with local colleges and other agencies.
- National Goal #8: To ensure the delivery of adequate services to expectant mothers and their newborn babies.
- National Goal #9: To identify high-risk mothers and children so that necessary medical, nutritional and other needed services can be available to them.

The goals, as stated, suggested that the Components should be involved in both case and class advocacy. That is, while the goals related to obtaining services, through referrals for families in the catchment area, reflect the need for a case approach, those goals concerned with the development and creation of resources require a class advocacy approach.

During the first half of the start-up year, little attention was focused on class advocacy issues. Components were primarily concerned with identifying families in the area so that (a) services could be delivered to meet needs, and (b) the project could become established in the community. However, as the mechanisms for referrals became established, attention was turned to the development of skills and mechanisms that would allow the Components to undertake class advocacy actions. Accordingly, most Components divided their staff

efforts so that ongoing families could continue to be served by the AC, while class advocacy projects were initiated. This division entailed a cut-back in the number of new families that were assessed. The manner in which most Components interpreted the national goals resulted in this decrease in recruitment of new families. However, this interpretation was not consistent with the expectations of the national AC staff. On the national level, the goals were understood to include ongoing assessment of new families, and relevant follow through at a consistent level of effort throughout the life of the program. However, staff size was not sufficient to permit equal focus on both case and class actions, so that priorities had to be established. At Components which emphasized class advocacy projects, the volume of needs assessments and the flow of referrals diminished noticeably. Differences in interpretation as to what the focus of the projects should be became a source of some conflict during the program, and there seemed to be considerable uncertainty as to whether the success of the national child advocacy program would be measured in terms of the number of families assessed and referred, or in terms of the number of new services and community projects initiated. Throughout the two years of program operation, this conflict around whether to stress case advocacy or class advocacy was never satisfactorily resolved.

In addition to setting action priority on the basis of class v. case advocacy, priorities had to be set so that all of the tasks indicated by the goals could be undertaken. When the ACs first began operations, staff expectations in terms of what could be accomplished in a limited period of time were quite unrealistic. AC staff expected to educate families to become their own advocates, to negotiate the service delivery systems independently and to organize as agents of change; they expected agencies to change their policies and to add new services; and they expected to mobilize new resources in the community. Clearly, these goals were too broad to permit immediate accomplishment. Thus, by the end of the start-up year, the individual Advocacy Components were stressing some of the national goals and de-emphasizing others, as a function both of the first year's experience and of the knowledge that there was to be only one additional year of program. Staff had learned that there was a need to set priority to objectives: given limited resources and extensive needs within the community, it was important to direct efforts selectively. Understanding that the project could not be "all things to all people," AC objectives were built around the need to combat problems in specific areas. While the activities relevant to assessing the community and providing information and referral services to families with a child 0-5 were never abandoned, and while

most ACs did try to relate to all the goals, the individual projects began to specialize, and thus to become unique. These patterns of specialization which were emergent at the close of the start-up year had, in several cases, become more evident during the second year of operation.

There are a variety of ways in which a particular Component may have come to develop a particular emphasis. In most instances, priorities were set when a gap was identified in the existing service delivery network. That is, the AC became established in the community and began to reach out to residents in order to assess their needs; coupling AC staffs' experience within the community with the reactions of residents, an area of need was clearly identified and the Component then mobilized its resources to fill the gap. This is the most obvious means for determining priorities, and one which was outlined by OCD guidelines and goals; it is not, however, the only way in which priorities were set.

In some cases, a particular emphasis grew out of the successful implementation of an activity which another agency(ies) wished to have repeated. Such expression of interest was often seen by the Components as an indication of having established credibility or having "passed the test." Therefore, when any such agency-accepted program capability was identified, it tended to be repeated, recognized by a wider audience, and established as a specialization. To the extent that there was

community need for such a capability, and to the degree that they complemented rather than supplanted existing agency operations, such specialities were similar in origin to those created in response to a gap in the service network. However, if and when the AC performed agency functions, or functions vital to agency operation, specialization often reflected growing agency dependency. Areas of emphasis that most commonly fell into this category were transportation and outreach.

Sometimes an area of specialization developed when a Component was invited to join in an inter-agency project. The experience, competency, and knowledge gained through this effort were incorporated by the AC staff and then translated into objectives and actions which allowed further use of these skills. As these new techniques were used more extensively, the projects began to be recognized as having a particular style, in terms of their involvement in a specific field.

Finally, an area of program specialization sometimes grew out of the expertise or interests brought to the job by staff members. This was most often true of the Coordinator who, in a leadership position, could most easily draw upon his or her experience to shape the direction of the program. Thus, it was not unusual to find that staff members had picked up on and incorporated the Coordinators' interests and style.

Regardless of the factors leading to any particular area of specialization, it was expected that activities would be directed to the national goals. Although in practice this often was not, and at times could not, be the case, the goals represented the uniform standard by which achievement across projects was measured.

2.0 THE NATIONAL GOALS

National Goal #1: To identify the unmet needs of low-income families with children 0-5 years in a designated catchment area.

As of June 30, 1974, 3,927 needs assessments had been completed; 2,422 had been completed by May, 1973; and 1,505 were done during the period of June, 1973 to June, 1974. In contrasting these sets of figures, it should be noted that prior to the summer of 1973 there were seven Advocacy Components; this figure was subsequently reduced to six.

Various difficulties encountered with respect to collection of needs assessment data were discussed in the final report of the start-up year. Some of these continued to trouble Components during the second year. Despite the mandate that assessment constitute an ongoing process, several Components found it difficult to assess new families while simultaneously maintaining ongoing service relationships with families. Consequently, the rate of new needs assessments

declined. During the January, 1974 Advocacy Meeting in Washington, D.C., the national staff reiterated its concern that the needs assessment process be continuous and be strengthened. For the two months following the Conference, the rate of completed needs assessments increased. Prior to this Conference, Components had been encouraged by the National Office to expand their catchment areas so that the base of families available for assessment would be broadened. Two Components expanded their areas prior to the Conference, and three Components expanded their areas just after the Conference. One of the three, Boston, expanded its area of service not so much to increase the assessment base, as to identify a population eligible for participation in an inter-agency demonstration project. With encouragement from the National Office and an increased service population, most AC staffs were actively recruiting new families until the announcement of project termination, made in the Spring of 1974. At this point, staffs turned their energies to phasing out, stabilizing and preparing ongoing families for termination.

At all Components, the data collected from the needs assessment were used primarily for intake into the program and for providing background information necessary for effecting referrals. The needs assessment served as an individual-specific, case history type of record containing information often not obtained, or obtainable, by service agencies. In this respect,

needs assessment data were valuable to AC staff in that they not only pinpointed areas requiring attention, but also provided staff with material that could be used to help agencies service a specific client, in a more responsive and personal manner.

While the importance of this aspect of the needs assessment process should not be minimized, it should be noted that in many cases opportunities to integrate and use assessment data in a wider range effort were not fully realized. Needs assessment data were not completely tabulated; neither were the instruments uniform among projects. Thus, the results of the assessment process could not be effectively used to present a profile of a population in need of service. Such a profile would have been useful to prospective program planners at the federal, state and local levels and, in addition, would have provided AC staff with an important, concrete documentation of need, useful in their efforts to mobilize community resources.

Of the six Components in operation the second year, only two, Cleveland and Huntington, had some form of structured tabulations available to them. At the Cleveland Advocacy Component, needs assessment data were hand tabulated. For the most part, however, these tabulations represented unanalyzed raw data. With the exception of information drawn from the assessments to show incoming AC families' use of Hough Norwood

immunization and prenatal services, these data were not formally used in conjunction with the Component's activities relevant to other community agencies. At the Huntington AC, data from the first 150 completed needs assessments were computer tabulated, and the information was made available for use by the Region II Health Planners and West Virginia University. Except in one case, where the use of assessment data as a referral tool was seen as the only end, AC Coordinators agreed that tabulations might have proved helpful. One additional Coordinator stated that it was unreasonable to expect that AC staff could work toward program goals and tabulate needs assessments.

An effort was made to secure some cross-project information. During the first program year, a supplemental form was added to the CCR Monthly Monitoring Report requesting data in such areas as immunization, public assistance, number of pregnant women identified, number of high-risk expectant mothers. When the Monitoring System was revised in September, 1974, CCR asked that the Components provide specific information on the trimester during which pregnant women begin receiving prenatal care, frequency of prenatal care, incidence of use of family planning services, frequency of receipt of dental care, number of children receiving immunizations as a result of AC intervention, number of children tested for lead poisoning and a classification, i.e., standard, substandard or deteriorated,

of the housing units in which Advocacy families live. In some cases, this request for additional data meant that Components had to revise their needs assessment instruments. Necessary changes were made so that by November, 1974, CCR was receiving information in these areas.

Additional information relevant to the goal of assessing community needs will be found in the chapters on families and on AC-agency relationships.

National Goal #2: To identify all private and public programs (local, state and federally-supported) that provide services for residents in the catchment area, and to compile information on existing community services.

Like the needs assessment surveys, the identification of community agencies was also an ongoing process. As the need for a greater variety of services was established, additional resources were sought by the Components and when services were available, linkages between the AC and the agency developed. While agency identification continued, the majority of activities in this area occurred during the first program year. During that year, all Components made extensive efforts to identify all agencies with bearing on AC families' lives in order to a) establish the Advocacy Component as a community-based organization, b) establish AC-agency linkages for the purposes of referral and community planning, and c) collect information for an AC published Community Resource Guide.

Toward the close of the start-up year and during the second program year, the procedures for AC identification of agencies began to change. At the start of the program, it was most common for the Advocacy Coordinator to take full responsibility for meeting with agency administrators, both to make initial contacts and to obtain preliminary information. As the AC outreach workers became more skilled, and as they increased their knowledge and sophistication, they began to share this responsibility with the Coordinators. The result of this was twofold: (1) an increased number of agencies could be covered; (2) the relationships needed for effecting referrals could be initiated by those persons who would actually be making and handling the referrals. In most instances, AC staff attempted to establish more than a simple referral linkage with agencies. Thus, during the second year, more effort was directed toward establishing and maintaining specialized AC-agency relationships through meetings, workshops, and joint project participation. These activities decreased as Components' staffs prepared to terminate the project. In some cases, preparation for termination involved many meetings with agencies in an effort to persuade community resources to incorporate some of the Advocacy functions into their procedures. These efforts and other information important to this goal are reported more fully in the chapter on AC-agency relationships.

In all, it may be said that with very minor exceptions, this goal has been attained: four Resource Guides have been produced, and all ACs have identified more agencies than has heretofore been identified by the PCCs in their respective communities. Some CCR interviews with agency heads in AC communities revealed that their agencies are using the ACs to gain information on available resources.

National Goal #3: To identify the gaps between needs and existing services.

Activities relevant to this goal were begun during the start-up year and continued and expanded during the second program year. For the most part, the initial procedure used to identify gaps was somewhat informal. That is, Advocacy staff, familiar with the community and aware of needs, met with agency administrators and called to their attention the existing gaps in service delivery. In few cases was this an effective means of encouraging change or mobilizing resources to fill service gaps, National Goal #4. However, during the second program year, more sophisticated activities were initiated. In some Components, identification was translated into documentation and the results of these efforts were more significant. For example, the Cleveland AC undertook two studies in the areas of housing and welfare in order to provide concrete documentation of need. Similarly, the Jacksonville Component was instrumental in heightening community awareness of the need for day care center licensing legislation.

The impact of these and other major efforts in this area are discussed in more detail in other chapters of this report. It is interesting to note here, however, that a new type of gap was identified: the gap that would exist in the majority of AC communities when the Advocacy project was terminated. Towards the end, a great deal of effort was directed toward publicizing the need for the continuation of the project and for the taking on of Advocacy functions by other agencies.

National Goal #4: To promote the development of community resources which will fill gaps in existing services.

While much first year activity focused on identifying gaps, the second program year saw increased efforts on the part of ACs to mobilize resources to fill these gaps. The most outstanding example of a new resource created to fill a gap in services was the establishment of health clinics in two counties in West Virginia. In some cases, ACs were successful in stimulating community agencies to provide service. For example, in Cleveland, AC staff worked closely with their delegate agency in drawing up a plan to eliminate the potential gaps created by AC termination: the delegate agency, the Center for Human Services, planned to fund a somewhat modified Advocacy project in Hough, and to work to create a county-wide Advocacy mechanism. In other instances, Advocacy staff, acting as coordinating agents, drew together agencies and joined these agencies in developing services to fill gaps. Examples of this

type of action include the Boston AC's efforts to demonstrate model procedures for implementing the state's 766 Equal Education Act, and Cleveland's demonstration project involving the provision of social services within public housing developments. In some instances, the ACs were able to fill gaps in terms of specific family needs, but not in terms of the needs of the entire community. For instance, some ACs arranged for preferential treatment for AC families which thus met their needs in a particular area, but this included no overhaul of the system which would ensure that all families could routinely have this need met.

While there were some outstanding examples of successful efforts to promote the development of resources to fill gaps in the service delivery network, many of the gaps that existed in the communities prior to the advocacy effort still exist. In retrospect, it was unrealistic to expect that these relatively small projects could in two years mobilize the vast network of local and federal agencies to fill gaps in health and social services that have existed for more than a hundred years.

Activities relevant to filling gaps in resources are discussed more fully in the chapter on AC-agency relationships.

National Goal #5: To assist in bringing together a comprehensive and efficient delivery system of services.

Since the start of the Advocacy program, realization of

this goal has constituted an important aspect of AC operations. During the start-up year, this goal was often translated into discrete activities on behalf of individuals. That is, activities were most often directed toward making the referral/service delivery process more efficient for AC-referred clients. While these efforts produced satisfactory results for AC families, the "rub off" effect or generalized carry over was minimal. In many instances, AC-referred families were receiving preferential treatment: agencies were not making the same level of effort to serve their non-AC clients. Recognizing this situation, Advocacy staffs moved to create a wider sphere of influence. These broader-based efforts, begun during the first year of operation, continued and expanded during the second year. Examples of relevant activities include the production of a patients' rights handbook by the Jacksonville AC and demonstration project by the Boston, Cleveland, and Huntington Components.

Similar to the three preceding goals, the processes involved in meeting this goal relate primarily to agency contacts and relationships. Thus, a complete discussion of this goal will be found in Chapter V.

National Goal #6: To assist families by referring them to specific agencies and follow through to ensure that the services are provided.

Referral activities constituted the major aspect of AC work.

While several Coordinators spoke of their project's movement from case to class advocacy, and while class advocacy activities have, in fact, been undertaken, the day-to-day business of the ACs remained family referral and follow-up to agencies. To date more than 5,675 referrals have been effected by the projects.

As a function of the comprehensive needs of many of the families, and because of the dearth of referral sources in the rural areas, there was a strong desire to provide direct services to families. Staff at these Components felt that merely effecting referrals was insufficient and that the OCD guidelines excluding direct services were restrictive. Since transportation problems are a major constraint to families seeking services, some Components felt that their effectiveness in making referrals was impaired without the ability to provide families with transportation.

Although in the national planning of the projects, it was intended that family needs would be met through referrals, in actual practice it turned out that this was not always possible. In many instances, families did not follow through on referrals even after repeated efforts on the part of AC staff. It became increasingly apparent that a population which is used to responding primarily to crisis situations is not likely to respond actively to referrals which are more related to prevention and less acute need. Moreover, many needs were identified which could not be met through referrals. For example, in the rural areas there simply is no agency to which housing referrals can be made.

The process of referral and the data relevant to this area are presented in Chapter III.

National Goal #7: To develop a training program for child advocates in concert with local colleges and other agencies.

Staff training within the Components has been continuous throughout the life of the projects. The results of these extensive efforts are evidenced by the increased sophistication with which AC staff members performed their jobs. However, in no instance has a specific course curriculum for training child advocates at local colleges been developed.

Further information relevant to Advocacy staff functions and training may be found in Chapter VI.

National Goal #8: To ensure the delivery of adequate services to expectant mothers and their newborn babies.

This goal was originally set as a priority for program attention. However, as the information from needs assessments began to be tabulated, it became evident that the population of pregnant women was not as large as had initially been expected, nor were their service needs as great. In all catchment areas combined, a total of only 672 pregnant women were identified. Of these, fewer than 100 women were not receiving prenatal care. While it appears that the majority

of expectant mothers were being cared for properly, this was not as true of their infants: 1,311 children were identified as unimmunized. Thus it has been the procedure for all ACs to include pregnant women and newborn babies in the general referral/service process, but to provide them with preferential treatment in the way of AC-sponsored activities and close follow-up.

Complete information pertinent to this goal is discussed in Chapters III and IV.

National Goal #9: To identify high-risk mothers and children so that necessary medical, nutritional and other needed services can be available to them.

As with pregnant women, high-risk mothers were not identified in as great numbers as was originally anticipated. Of the 672 pregnant women identified during the life of the program, 73 (11%) had a high-risk history and 183 (27%) were under 18 years of age. Therefore, the work done for and with the children of these women was similar to that done for all target families.

As part of their first year objectives, two ACs specified an emphasis on high-risk pregnant women and planned special programs accordingly. Throughout the life of the projects, one Component, the Baltimore AC, initiated and continued a program for teenage mothers. All other Components worked

with these families as they would with other AC families, giving preferential treatment and attention as indicated.

In the final report of the start-up year, CCR identified an additional goal not included in those outlined by OCD. This goal is defined as follows:

- To heighten family awareness and utilization of existing resources and to encourage the development of community organization efforts at the family level.

This goal implicitly underlies all AC family-related activities in that it describes the anticipated outcome of all Advocacy efforts. While all Components have worked toward creating a "knowledgeable clientele," work in this area increased as the program drew to a close. Coordinators and staff became even more aware of the need to ensure that families would be able to competently negotiate the various service delivery systems.

While the emphasis on education of families was great and in the beginning Coordinators spoke of "working themselves out of a job" in the sense that families would become their own advocates, by the end of the program all Coordinators discussed the unrealistic quality of this expectation. Some families did become somewhat more active in their own behalf,

but the majority did not learn to become their own advocates both in terms of personal family needs and community efforts.

Information on progress made toward attainment of this goal is detailed in the remainder of this report.

CHAPTER III

THE AC AND ITS RELATIONSHIP WITH FAMILIES

Data presented in this chapter reflect AC activities on behalf of individual families, and the relationships between the Advocacy Components and the families served. The discussion is based on information collected from each of the Components through the Monthly Monitoring System. Using this system, AC staff were asked to supply the following kinds of program statistics:

- number of telephone calls made to families each month
- number of home visits
- number of referrals
  - brief description of specific reason for referral
  - outcome of each referral

1.0 KNOWN CHARACTERISTICS OF THE AC POPULATION

The data presented in Table III-1 below, were taken from the Supplementary Monitoring Form. With the exception of asterisked items added to the form in October, 1973, the materials represents cumulative statistics over the life of the program. As no two Components used the same needs assessment instruments, these data represent the only uniform information available relating to the demographic and need characteristics of the AC population. Design and use of a data gathering instrument was recommended by CCR to OCD, but the desire to permit the PCC/ACs to develop their own instruments at the local level outweighed CCR's view of the advantages of obtaining comparable data on the AC population.

Table III-1. Characteristics of the AC population; based on information from 3,927 needs assessments.

	TOTAL
*Type of housing in which families reside: Base = 853	
% Living in standard housing	(64)
% Living in deteriorated housing	(19)
% Living in substandard housing	(17)
Number of families receiving public assistance	2,322
% Receiving public assistance	(59)
Number of families receiving Commodities/Food Stamps	1,533
% Receiving Commodities/Food Stamps	(39)
Number of families receiving Medicaid	1,445
% Receiving Medicaid	(37)
Children 0-5	6,666
Pregnant women	672
Receiving pre-natal care	585
% Receiving pre-natal care	(87)
High-risk pregnant women	73
Pregnant women under 18	183
*Trimester during which care began: Base = 127	
% beginning in first trimester	(53)
% beginning in second trimester	(40)
% beginning in third trimester	(7)
Frequency of pre-natal care visits: Base = 127	
% Once every 1-4 weeks	(69)
% Once every 5-8 weeks	(27)
% Once every 9+ weeks	(4)
*Women using family planning	452
% of women assessed (Base = 853)	(53)
Unimmunized children	1,311
% of all children 0-5 identified	(20)
Children not receiving medical attention	774
% not receiving medical attention	(12)
Number of individuals who have never been to a dentist	803

* Figures from October, 1974

Needs assessments were conducted on a total of 3,927 families, including 6,666 children ages 0-5. Over one-half of these families were receiving public assistance, over one-third were enrolled in Medicaid, and over one-third received food stamps or commodities at the time of the assessment. The majority of families (64%) assessed between October and June were judged to live in standard housing while 19% resided in deteriorated housing, and the remaining 17% lived in substandard dwellings.[1] Thus 36% of the families live in housing which is inadequate and not conducive to good care of children. It is not surprising that housing problems became an overriding concern at several ACs. As discussed in Chapter V, the Cleveland AC, in particular, made a sustained effort to document housing needs, and to effect housing legislation.

A specific goal of the program was the identification and referral of pregnant women. However, inspection of the data shows that the level of need identified was not as high as

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[1] Standard housing was defined as units which have no major defects and contain all plumbing facilities including indoor toilet, hot and cold running water, and a tub or shower. Deteriorated housing was defined as those housing units which have all plumbing facilities, but which have some defects, e.g., falling plaster, pests, faulty heating or plumbing, inadequate ventilation, inadequate garbage disposal. Substandard housing units are defined as those which lack one or more plumbing facilities, and which have a combination of defects creating present dangers to the health and safety of the occupants; defects are so extensive that the structure needs extensive repairs, rebuilding or demolition.

originally anticipated. Six hundred seventy-two pregnant women were identified; of these 73 were considered high-risk and 183 were under 18 years of age. Of all expectant mothers identified, only 13% were not receiving pre-natal care. Of the 127 pregnant women assessed by the ACs from October to June, the majority (53%) reported that they had begun receiving pre-natal care during their first trimester; only 7% reported having waited to seek medical attention until the end (third trimester) of their pregnancy. Similarly, 69% of these women reported receipt of pre-natal care once every 1 to 4 weeks while only 4% saw the doctor once every nine or more weeks.

Several Components developed a focus on family planning activities. Therefore, CCR added an item to the Supplementary Form in October, asking for information on the number of women using family planning at the time of assessment. Using a base of 853, it was found that 452 or 53% of the women assessed reported using some form of birth control.

The concern about children's immunizations was supported by the program's experience. Twenty percent of the children ages 0-5 were not immunized at the time of the needs assessment. In addition, 12% of the children were not receiving regular attention.

2.0 TELEPHONE CONTACTS

Table III-2 below presents the number of phone calls to families made by the four urban Components, the number made by the two rural Components, the number of different families

telephoned, the mean number of calls per family that received a call, the range of numbers of calls made to a family, i.e., the least and most number of phone calls made to individual families. All figures represent the number of calls made from October 1973 through June 1974.

Table III-2. Telephone contacts.

	NUMBER OF TELEPHONE CALLS	NUMBER OF DIFFERENT FAMILIES CALLED	MEAN NUMBER OF CALLS/ FAMILY CALLED	RANGE OF NUMBER OF CALLS TO SINGLE FAMILIES
Urban	1,905	737	2.58	1-21
Urban Component ranges	173-633	107-254	1.62-3.45	
Rural	175	73	2.39	1-9
Rural Component ranges	60-115	17-55	2.09-3.53	
TOTALS	2,080	810		

Staff members were asked to include in their reports those calls which were made for purposes other than referral or follow-up. Therefore, the figures represent only those calls made in order to keep in touch or maintain the AC-family relationship.

The number of telephone calls made, and the number of different families called, are fewer in rural than in urban Components. In rural ACs, telephones did not constitute a

realistic mechanism for maintaining contact with families, as few families had telephones.

However, even in urban Components there was tremendous variability in terms of the frequency of telephone calls to families; no consistent program of maintaining routine telephone contact existed at any of the Components.

Comparisons with data from the first year show a high degree of consistency. Whereas the mean number of calls/family in the urban ACs was 2.58 in the second program year, in the first it was 2.62. In the rural programs the year two mean was 2.39 as compared with 1.95 the first year.

3.0 HOME VISITS

The data on home visits include visits made in order to effect or follow up on a referral, as well as visits made to maintain contact, provide support, and express interest in the family. Again, the figures represent activities between October 1973 and June 1974.

Table III-3. Home visits.

	NUMBER OF HOME VISITS	NUMBER OF DIFFERENT FAMILIES VISITED	MEAN NUMBER OF VISITS/ FAMILY VISITED	RANGE OF NUMBER OF VISITS TO SINGLE FAMILIES
Urban	3,497	1,204	2.90	1-50
Urban Component ranges	291-1,682	196-387	1.48-5.27	
Rural	4,069	643	6.33	1-64
Rural Component ranges	877-3,192	254-319	3.58-7.86	
TOTALS	7,566	1,847		

As contrasted with telephone calls, home visits represented a more frequently used mechanism for keeping in touch with families. This was particularly the case in rural Components where the mean number of visits per family was more than twice as great as was the mean among urban ACs. As with telephone contacts, the range of visits made to families was great; this is especailly true in the case of the total number of visits conducted (291 in one urban Component and 1682 in another; 877 in one rural Component and 3,192 in the other). As would be expected, those Components which reported visits to a larger number of different families saw those families less often than did those Components which visited fewer families. As indicated by the figures in the "range" column, some families received far more visits than did others. Frequent visits to a particular family were generally related to the special needs of families during crisis periods.

At four Components, the central purpose of home visits was to motivate families to accept referrals. AC-family contact, in terms of the number of home visits, was greatest when related to specific referrals. Once referral-related needs were met, staff maintained minimal contact with families, letting the families know that if they needed help they should get in touch with Advocacy. Since the focus of the staff-family relationship is centered on helping the family negotiate specific systems in the context of referrals, this may be called the ombudsman model of case advocacy. Two Components used ongoing home visits for the purpose of maintaining contact,

providing supportive services around issues which could not be handled by means of a referral. Since the focus of the staff-family relationship is on providing support as well as on referrals, this may be called the friendly visitor model of case advocacy.

These two approaches represent two very different models of service delivery in a case-advocacy context, as is highlighted below:

Ombudsman model	Friendly visitor model
initial needs assessment	initial needs assessment
↓	↓
referrals	referrals
↓	↓
family is notified that they can call the AC if any new needs develop	continued visits for support, exploration of new needs, education

Considering that Advocacy was defined by OCD as a model designed to meet needs by means of referrals and through local service integration, the friendly visitor model was probably an inappropriate service delivery mechanism within the context of this particular demonstration. However, it developed as a function of the growing awareness that not all family needs can be met through referrals, and that sometimes just having a sympathetic ear and a sounding board can be extremely helpful.

4.0 REFERRALS

Table III-4 below presents data on referral activities between October 1973 and June 1974. A referral is defined as the notification of a family, as well as of a resource, that the services of the resource are needed; and the implementation of appropriate follow through to ensure that an

appointment has been made.

Table III-4. Referrals.

	NUMBER OF REFERRALS	NUMBER OF DIFFERENT FAMILIES REFERRED	MEAN NUMBER OF REFERRALS/ FAMILY
Urban	1,009	799	1.26
Urban Component ranges	182-317	145-258	1.08-1.64
Rural	2,216	1,636	1.31
Rural Component ranges	413-1,803	242-1,394	1.29-1.70
TOTALS	3,225	2.435	

During the nine month period, the six Components made a total of 3,225 referrals on behalf of 2,435 families. The mean number of referrals/family was similar for both urban and rural projects. However, as can be seen from the ranges presented, one rural Component referred almost twice as many families as did all four urban Components together. However, this large number of referrals in the rural Component is really an artifact of definition. The Leitchfield AC was able to effect a very large number of referrals as a result of having transportation aides and homemakers on staff. With the availability of transportation, a direct service that was permitted in rural areas only, the Leitchfield AC was able to utilize resources in cities outside of their catchment areas, previously not accessible to AC families. In addition, the Component made

arrangements with local agencies whereby the AC transportation staff performed tasks for these agencies. Therefore whenever the AC transported families for other agencies they reported this as AC referral activity to CCR. In addition, the use of PCC/AC homemakers to conduct individualized sessions in the families' homes contributed to this Component's high referral rate. In a sense, therefore, the referral figures from this AC are highly inflated. In fact, 560 of the reported referrals for this AC are for transportation.

During both program years, in all Components with the exception of Leitchfield, which had an inflated number of referrals, as noted above, the number of home visits exceeded the number of referrals. There are a number of reasons that, typically, the number of home visits exceeded the number of referrals. First, home visits were often a part of the referral process. That is, for a given referral, the worker may have made an initial home visit to either assess the problem or to make preparations for the referral, a follow-up home visit once the service was received, and any number of intervening home visits in cases where the family had either missed an appointment or had need of additional and/or different services. Considerable problems were associated with motivating families to use resources and to keep scheduled appointments. Even when AC staff provided transportation to services, accompanied the families during the service delivery process, and made repeated home visits around a single referral, the number of families failing to use the resource was still high. The

fact that many families, particularly urban ones, were already using a number of resources at the time they were assessed by the ACs was another factor contributing to the low referral/home visit ratio. While the Components did connect families with needed and previously unused services, resources such as Public Assistance, food stamps, Medicaid, and local health clinics were already well known and used. For urban AC staffs, a major portion of interaction with families focused around helping families to better use the available services, and mediating family-resource negotiation problems, both of which required more home visits than referrals. In addition, as already discussed, there were many families more in need of a "friendly visitor" than of a referral to a resource.

4.1 Types of referrals

A tabulation of referrals by major service area is presented below in Table III-5.

Table III-5. Number of referrals in major service areas.

TYPE OF REFERRAL	TOTAL NUMBER OF REFERRALS	URBAN REFERRALS	RURAL REFERRALS
Health	1,277 (40)	338 (34)	939 (42)
Educational	479 (15)	310 (31)	169 (8)
Welfare	409 (13)	110 (11)	299 (14)
Housing	180 (6)	109 (11)	71 (3)
Employment	90 (3)	40 (4)	50 (2)
Psychological	71 (2)	37 (4)	34 (2)
Miscellaneous	719 (22)	65 (6)	654 (30)
TOTAL NUMBER OF REFERRALS	3,225	1,009	2,216

The single largest referral category (40%) was for health care services. This was true both in urban (34% of all referrals) and rural (42%) projects. This represents almost no change from the first year when health referrals represented 42% of all referrals. Among rural ACs the lower level of health care made health care needs a particular priority: there were more unimmunized children, more children who had never seen a dentist, and more children who were not receiving medical care.

Educational referrals accounted for 15% of referrals across all Components, but for almost one-third (31%) of all referrals made by urban Components. As will be seen in the following tables, referrals to the PCC largely account for

this high proportion. Educational referrals the first year represented 14% of all referrals.

Welfare referrals account for 13% of all referrals. This represents a slight shift from the first year when welfare represented 9% of all referrals.

Housing referrals account for only 6% of all referrals which is a decrease from the 14% of housing referrals during the first year. This decrease in housing referrals reflects growing awareness that housing referrals are unlikely to have a positive outcome, and that housing problems need to be handled on a class rather than case by case basis.

Employment (3%) and psychological (2%) referrals were relatively rare in the second year and in the first as well (employment =5%, psychological = 1%).

Miscellaneous referrals account for a large proportion of referrals (22%) because this category includes referrals for clothing, food, and transportation. Such referrals account for only 9% of all referrals in the first year because transportation services were not counted as a referral until the second year of the program.

4.1.1 Health-related referrals

Presented below is an itemization of the types of problems and services for which health-related referrals were effected.

Table III-6. Health-related referrals.

HEALTH-RELATED REFERRALS		TOTAL	URBAN	RURAL
Immunizations	#	234	49	185
	%	(18)	(15)	(20)
Check-ups		174	69	105
		(14)	(20)	(11)
Doctor visit for medical problem		124	19	105
		(10)	(6)	(11)
Dental work		129	18	111
		(10)	(5)	(12)
Family planning		112	8	104
		(9)	(2)	(11)
Tests		87	58	29
		(7)	(17)	(3)
Pre-natal care		82	25	57
		(6)	(8)	(6)
Dental check-up		70	23	47
		(5)	(7)	(5)
Medication		41	1	40
		(3)	(*)	(4)
Nutrition/Vitamins		37	10	27
		(3)	(3)	(3)
Eye check-up		38	8	30
		(3)	(2)	(3)
Enrollment for medical coverage		25	24	1
		(2)	(7)	(*)
Health/Nutrition education		29	1	28
		(2)	(*)	(3)
Speech		27	3	24
		(2)	(1)	(3)
Surgery		11	1	10
		(1)	(*)	(1)
Glasses		18	8	10
		(1)	(2)	(1)
Hearing		13	2	11
		(1)	(1)	(1)
Medical miscellaneous		26	11	15
		(2)	(3)	(2)
TOTAL		1,277	338	939

* Percent equals less than 1

In the rural Components, immunizations, check-ups, doctor visits, family planning and dental work constituted the largest categories of all health referrals. Check-ups, immunizations and tests, primarily lead poisoning tests, were the major reasons for health-related referrals in the urban projects.

As discussed in Section 1.0 of this chapter, uniform data from all Components on identified needs are available in relatively few areas: immunizations, medical care, and dental care.

Presented below are data already presented in Table III-1 in order to demonstrate the relationship between family needs and AC referral activities on behalf of families. Where possible, numbers represent data over the course of the whole Advocacy demonstration: May 1972 - June 1974.

Table III-7. Health needs and AC referral activities.

NEEDS IDENTIFIED		AC REFERRALS
Number of unimmunized children:	1,311	574
% of children immunized through AC referral		44%
Number of children not receiving medical care:	774	464
% of children receiving health check-ups through AC referral		60%
*Number of individuals who have never been to a dentist:	803	129
% of individuals receiving dental check-up through AC referral		16%

* Data are based on October, 1973 - June, 1974 only.

It is apparent that there were many instances of identified health needs which Advocacy was unable to resolve. The proportion of dental referrals relative to identified need is particularly low because the number of individuals who have never been to a dentist includes children 0-3 who may have no need of a dentist and because dental care in the rural areas is virtually non-accessible to low-income families, and because families avoid going to the dentist except in cases of acute pain. To put it simply, preventative dental care is very hard to "sell."

The rate of immunizations and health care referrals is also low in proportion to the need identified. There are two reasons why this occurs. First, many families simply refused to have their children immunized, and no amount of coaxing or advocating by AC staff caused them to change their mind. Second, families are difficult to motivate around preventive health care. Accustomed to seeking medical care only when a child is ill, taking a healthy child for immunizations and check-ups seems unnecessary. While some pediatricians specializing in child neglect cases feel that failure to immunize a child is an act of omission which threatens the child's health and which should therefore be reported to child protective services, the ACs did not take this type of action. Hence, where the staff could not persuade a mother to have her children immunized or checked, the topic was eventually dropped.

4.1.2 Education-related referrals

Table III-8. Education-related referrals

EDUCATION-RELATED REFERRALS		TOTAL	URBAN	RURAL
PCC enrollment	#	205	151	54
	%	(43)	(49)	(32)
Head Start enrollment		78	36	42
		(16)	(12)	(25)
Day care services		58	58	0
		(12)	(19)	(0)
Adult basic		55	26	29
		(11)	(8)	(17)
Kindergarten enrollment		20	20	0
		(4)	(6)	(0)
School transfer		21	12	9
		(4)	(4)	(5)
Educational miscellaneous		42	7	35
		(9)	(2)	(21)
TOTAL		479	310	169
		(99)	(100)	(100)

Among urban ACs, referrals to PCC accounted for 49% of all actions in this area. Particularly in two urban communities, the Components took on the responsibility of actively recruiting new participants for the Parent-Child Centers. While the national guidelines stated that ACs could not service PCC families, there was no stipulation against use of AC staff on behalf of the PCC. Thus, in some cases, the PCCs took advantage of the Components' outreach capacity to recruit new members. Although the percentage of rural referrals to PCC is not as high as that for urban projects, it does

constitute the single largest category of referral in this area (32%).

Among urban projects, almost one-fifth (19%) of the education-related referrals were for day care services; such services were not available to rural families. However, one quarter of the rural referrals were to Head Start, twice as many as were made by urban ACs.

4.1.3 Welfare-related referrals

Table III-9. Welfare-related referrals.

WELFARE-RELATED REFERRALS		TOTAL	URBAN	RURAL
Food stamps/Commodities	#	195	16	179
	%	(48)	(15)	(60)
Special services/ Emergency grants		67 (16)	52 (47)	15 (5)
Medicaid		66 (16)	9 (8)	57 (19)
Enrollment		43 (11)	19 (17)	24 (8)
V.A. or Social Security		19 (5)	3 (3)	16 (5)
Increased payment		12 (3)	7 (6)	5 (2)
Problems with DSS staff		3 (1)	3 (3)	- -
Welfare miscellaneous		4 (*)	1 (1)	3 (1)
TOTAL		409 (100)	110 (100)	299 (100)

In the rural areas, food stamps/commodities represented the single largest welfare-related referral category (60%). In one community this large referral rate was due to a shift from commodities to food stamps. In these cases, outreach workers often acted as facilitators or mediators to help families make the transition. Special services or emergency grants accounted for 47% of the urban welfare-related referrals. Although most often requested funds were for furniture, this category also included requests for clothing allowances and emergency subsidies when a family's monthly allotment was exhausted.

Although a substantial proportion of AC families received welfare payments prior to the advent of the projects, in the second program year, 19% of the rural welfare-related referrals were for Medicaid enrollment and 17% of the urban referrals were for general welfare enrollment. Thus, it seems that while people may have been enrolled, many were not receiving their full benefits.

4.1.3 Housing-related referrals

Table III-10. Housing-related referrals.

HOUSING-RELATED REFERRALS		TOTAL	URBAN	RURAL
Relocation	#	105	69	36
	%	(58)	(63)	(51)
Household appliances/ Furniture		30	6	24
		(17)	(6)	(34)
Physical improvement/ Repairs		13	11	2
		(7)	(10)	(3)
Pest control		7	7	-
		(4)	(6)	-
Housing miscellaneous		25	16	9
		(14)	(15)	(13)
TOTAL		180	109	71
		(100)	(100)	(101)

The majority of housing-related referrals among both the urban and rural ACs were for relocation (63% urban and 51% rural). The category of relocation reflects dissatisfaction with present dwelling because of space problems (too large, too small), condition, or location. As with job placement, a relocation referral might have been made at the family's request although the worker might not have known of any available units. That is, these referrals were often made to real estate agents who tried to find suitable space for the client. However, within each of the catchment areas, housing represented a major problem area both in terms of the condition of AC family dwellings and the availability of other suitable dwellings.

While this was true in both urban and rural locations, the rural ACs and their families faced the additional problems posed by storm, floods and, in Leitchfield, a tornado, all of which adversely affected housing units. The destruction of property brought about by environmental conditions also accounted for at least some of the 34% of the rural housing referrals made for appliances and furniture. This category, however, also included cribs, beds and baby furniture, needed for reasons other than disaster. The percentage of such referrals was lower in the urban areas as these needs were most often referred to the Department of Social Services which could supply emergency (furniture) grants.

4.1.5 Employment-related referrals

Table III-11. Employment-related referrals.

EMPLOYMENT-RELATED REFERRALS		TOTAL	URBAN	RURAL
Job placement	# %	58 (64)	20 (50)	38 (76)
Job training/Rehab		21 (23)	19 (48)	2 (4)
Temporary job placement		7 (8)	1 (3)	6 (12)
Vocational testing/ Counseling		4 (4)	- -	4 (8)
TOTAL		90 (99)	40 (101)	50 (100)

During the nine month period, the ACs made 90 employment-related referrals. Employment represented an area of great

need among Advocacy families. In both urban and rural ACs, job placement was the most frequent reason for an employment-related referral (50% of urban referrals; 76% of rural). However these large percentages represent a maximum of only 58 persons. (The number was probably lower as referrals of this nature often required follow-up appointments). The fact that the number of referrals for job placement was so low might be an indication of awareness, among both staff members and families, that it was extremely difficult, if not impossible, to find jobs.

Urban referrals for job training represent primarily the efforts of one Component. This AC sponsored a six-week employment workshop at the end of which 16 persons were referred to a training program.

4.1.6 Psychological referrals

Table III-12. Psychological referrals.

PSYCHOLOGICAL REFERRALS	TOTAL	URBAN	RURAL
Psychiatric care/Counseling # / %	57 (80)	35 (95)	22 (65)
Developmental/ Behavioral problems	6 (8)	- -	6 (18)
Psychological testing	5 (7)	1 (3)	4 (12)
Retardation	3 (4)	1 (3)	2 (6)
TOTAL	71 (99)	37 (101)	34 (101)

The majority (80%) of referrals in this area were made for psychiatric care or counseling. In the urban Components, the fact that 35 referrals were made in this category was due primarily to the activities of the Cleveland AC. The Component's delegate agency provided the AC staff with a part-time caseworker/counselor to whom it can be assumed the majority of these referrals were made. In the rural Components referrals were made most often to County Mental Health Departments and special classes.

4.1.7 Miscellaneous referrals

Table III-13. Miscellaneous referrals.

MISCELLANEOUS REFERRALS	TOTAL	URBAN	RURAL
Transportation #	257	13	244
%	(36)	(20)	(37)
Clothing	184	15	169
	(26)	(23)	(26)
Homemaker	159	3	156
	(22)	(5)	(24)
Food	76	18	58
	(11)	(28)	(9)
Legal assistance	29	9	20
	(4)	(14)	(3)
Foster home/Adoption/ Custody	9	5	4
	(1)	(8)	(1)
Abortion/Placement for unwed mothers	2	2	-
	(*)	(3)	-
Child Abuse	1	-	1
	(*)	-	(*)
Baby sitting	2	-	2
	(*)	-	(*)
TOTAL	719	65	654
	(100)	(101)	(100)

Rural Components referred ten times as many people for needs described in this area than did urban ACs. Of the 654 rural AC families referred for miscellaneous reasons, 400 or 61%, were referred to AC workers for transportation and/or homemaker services in the Leitchfield AC. Referrals for clothing represented another major referral category among rural ACs (26%). For the most part, these referrals had successful outcomes as Components had built relationships with specific agencies that provide emergency clothing.

Among urban ACs, food, clothing, and transportation were the most frequent categories of support service referrals. These three categories represent 41 persons or 71% of the families who received miscellaneous referrals.

4.2 The outcomes of referrals

Presented in Tables III-14a and III-14b are the outcomes associated with referrals made on behalf of the urban and rural AC families.

Table III-14a. Urban referral outcomes.

CATEGORY		1	2	3	4	5
Health	#	11	18	3	47	248
	%	(3)	(6)	(1)	(14)	(76)
Educational		12	6	31	123	121
		(4)	(2)	(11)	(42)	(41)
Welfare		0	0	11	43	56
		(0)	(0)	(10)	(39)	(51)
Housing		2	4	16	50	34
		(2)	(4)	(15)	(47)	(32)
Employment		4	1	8	41	17
		(6)	(2)	(11)	(58)	(24)
Psychological		1	2	0	6	26
		(3)	(6)	(0)	(17)	(74)
Miscellaneous		2	0	1	18	20
		(5)	(0)	(2)	(44)	(49)
Base: Total # Referrals by outcome		32	31	70	328	522
% of Total Referrals made		3	3	7	33	53

1 = Appointment not kept, end of referral
2 = Appointment not kept, rescheduled
3 = Services cannot be provided or family ineligible
4 = Appointment kept, need follow-up or awaiting action by resource
5 = Problem resolved

The great majority of referrals (86%) had a successful (53%) or a partially successful outcome (33%). However, it is important to note that successful outcomes varied as a function of the type of problem referred and that partially successful outcomes in some cases can be counted as a success and in others can be counted as no more than placement on a long waiting list. For example, a visit to the doctor which requires a follow-up appointment can be counted as a success since the problem is in the process of being treated, whereas placement on a waiting list for new housing in no way ensures that the family will ever move.

Seven percent of all urban referrals resulted in the family not receiving service because of ineligibility or unavailability of service. This was especially true in the categories of education, employment, housing and welfare. In only six percent of referrals were appointments recorded as not kept. Relating this figure to comments made by Coordinators, it is clear that this 6% represents a gross underestimate for first appointments. Often families did not keep first or second appointments and had to be repeatedly urged to follow through. Earlier attempts to motivate families often went unrecorded.

Seventy-six percent (76%) of all urban health referrals had a positive outcome and an additional 14% had a near positive outcome in the sense that some action had been taken and a follow-up appointment was made.

In terms of educational referrals, 41% had a positive outcome and 42% resulted in placement on a waiting list. Most of those resulted in eventual placement in the PCC or Head Start.

The high proportion of successful welfare-related referrals (51%) is interesting when contrasted with the low success rate during the first program year. During the start-up year, more referrals were made in this category, but fewer resulted in positive outcomes (17%). The figures for the second year may represent an indication of the improved relationship between Departments of Social Services and Advocacy Components during this period.

The two categories in which successful outcomes were low, were employment and housing. The problem was not that the Components were unable to make the proper referrals in these areas, or that the Components had not established linkages with the appropriate agencies, but rather that both employment opportunities and housing were scarce. While the proportions of families placed on waiting lists were high (employment: 58% and housing: 47%), it could not be expected that the majority of outcomes would be positive. Actual jobs were in short supply, and while job training programs were available, there was little guarantee that graduates could be placed. Housing presented a similar problem in that few sound financially viable units existed in the catchment areas.

While the total number of referrals made in the category

of "psychological" was small, the proportion of "problem resolved" outcomes (#5) was as high as that for health. In this instance it should be noted that an outcome 5 probably refers more to the fact than an appointment was kept and a service of some kind performed rather than the actual "resolution" of a problem.

Miscellaneous referrals had a high success rate (49%) because in most cases these referrals were for simple concrete services, e.g., food, clothing, transportation, that could easily be provided for families through the ACs linkages with charitable and social-service type agencies.

Table III-14b. Rural referral outcomes.

CATEGORY		1	2	3	4	5
Health	#	29	102	8	474	325
	%	(3)	(11)	(1)	(50)	(35)
Educational		21	3	20	55	70
		(12)	(2)	(12)	(34)	(41)
Welfare		2	7	16	165	109
		(1)	(2)	(5)	(55)	(37)
Housing		1	0	7	22	41
		(2)	(0)	(10)	(31)	(58)
Employment		3	1	3	25	18
		(6)	(2)	(6)	(50)	(36)
Psychological		0	5	0	25	4
		(0)	(15)	(0)	(73)	(12)
Miscellaneous		1	40	6	155	389
		(*)	(7)	(1)	(26)	(66)
Base: Total # Referrals by outcome		57	158	60	921	956
% of Total Referrals made		3	7	3	43	44

1 = Appointment not kept, end of referral
2 = Appointment not kept, rescheduled
3 = Services cannot be provided or family ineligible
4 = Appointment kept, need follow-up or awaiting action by resource
5 = Problem resolved

Referral outcomes for the rural Components show trends similar to those outlined for the urban projects. Overall, a total of 87% of the referrals resulted in either problem resolution (44%) or outcome 4, appointment kept, need follow-up or awaiting action by resource (43%). This was especially true in the case of miscellaneous referrals (92% of outcomes

were either #4 or #5). As was noted, miscellaneous included tangible services and in the case of the Leitchfield Component, services that could be provided directly by AC staff, particularly transportation and homemaker services. As was the case in the urban ACs, over three-quarters of the health-related referrals had positive or near positive outcomes.

While only 10% of the referrals resulted in either a #1 or #2 outcome, this might be an underestimate as was noted in the description of urban referral outcomes.

5.0 SUCCESSES AND FAILURES: SOME ILLUSTRATIVE EXAMPLES

The ACs made many successful referrals on behalf of families, although the expectation that all families referred would be helped was not met. Some needs, particularly in housing and in employment, were not met due to non-availability of resources, other needs were not met because families were resistant to AC intervention or because they could not be motivated. All of the ACs described cases of families which they considered had been helped a great deal and cases of families which they had not been able to reach. The following are examples of both successes and failures.

5.1 Successes

° Family #1 - One child with cerebral palsy received therapy and extensive medical equipment and the mother was given information regarding his care and training to administer therapy. A second child, with a heart condition, was accepted by Crippled Children and was treated by them.

° Family #2 - A child with a heart condition was seen by Crippled Children and received a diagnostic examination and medication. Upon examination an orthopedic condition was also found and treated. The mother needed instruction and support in learning to cope with the child in order to promote development, despite his disabilities. The father received surgery to insert a pacemaker. He is also almost totally deaf, diabetic, has a kidney condition, poor vision, prostate condition and respiratory problems. He will receive a hearing aid and further surgery when his condition permits.

° Family #3 - The mother was concerned that something was wrong with her four year old child and took him to the Children's Clinic. He was subsequently hospitalized but they had not diagnosed his problem. The AC followed up on this. The local Health Nurse assured AC that the P.K.U. test had been given and that there was no chance that it was P.K.U. But after much encouragement and several appointments with Comprehensive Care and Children's Hospital, it was found that he was a P.K.U. baby. The family is now drawing SSI and the child is going to a school for the handicapped. Since attending the school, the child is toilet trained which the mother had tried before without success, and the mother is relieved of the burden of continuous care.

° Family #4 - Advocacy provided medical and dental help for the children. The mother is using family planning and the children have been immunized with Advocacy intervention. The

mother has been sewing and making clothing for the children, drapes and curtains for the home. Two of the five children are mentally retarded and one of these children has been enrolled in the Advocacy Head Start program and the regular Head Start session. The oldest child, also retarded, has been referred to the Commission for Handicapped Children and another child has been going to a Comprehensive Care Speech Therapist for evaluation. The father was referred for employment.

° Family #5 - This family has eight children - age two to seventeen years. The family was in need of health, education, and welfare assistance when the AC first made contact with the mother. The mother was very ill - she had been in an automobile accident, suffered a mild brain concussion, and continued to experience severe anxiety. Advocacy made special arrangements for the mother to enroll her two-year-old in an all day, day care center for working mothers; the child was accepted under the condition that the child would be dropped as soon as the mother was better. In making regular visits to the home to see how the family was getting along, the AC found the family in need of food. The family received food stamps but the mother was unable to purchase the stamps that month because she had three children graduating from school which created additional expenses. Advocacy contacted the Salvation Army for an emergency food order and the family received it. The family also received clothing as a result of a referral. After the AC became more familiar with the mother, the worker could see that the mother's anxiety was not diminishing so the AC suggested that she attend

the Child Guidance Clinic. As a result her condition is reported to have improved.

° Family #6 - The mother is 24 years of age, pregnant, and unmarried, with three children, under the age of seven. The mother was referred for psychiatric services because she had unrealistic fears about sending any of her children to school. She became convinced that she should send her six year old child to school, for the first time. Previously, the child attended school two or three days out of a nine-month period. Additionally, the family was referred for, and received, food stamps, and when the family was threatened with eviction Advocacy provided help to prevent this. The mother delivered a fine baby girl, and the children are attending school regularly. The mother has begun to show initiative in terms of getting services for herself and her family.

° Family #7 - The mother has six children, three of whom live at home - ages 17, 15 and 4 years. The four year old was born blind. The mother is working and could not find day care for her blind child. The 17 year old daughter had to stay home from school some days to take care of the child, which got her in trouble at school. Advocacy intervened to explain the situation to the school. After many referrals, several eye operations, and close collaboration with the Bureau of the Blind services, Advocacy finally got Head Start to accept the child. In the meantime, the older sister became pregnant and Advocacy referred her to the clinic for pre-natal care and delivery.

° Family #8 - This family consists of a mother, her five children, and her 15 month old grandchild. The mother had been in treatment of hypertension and depression for the past six years. In addition, she was under heavy medication and suffered from severe migraine headaches which made it uncomfortable for her to endure both light and sound. The AC became involved with this family when the mother complained of difficulties with the hospital. The mother said that she was receiving no relief and felt that her headaches were physical and that she needed an EEG. The doctors, on the other hand, wanted to admit her to a psychiatric hospital and told her that they would not give her the examination she wanted unless she agreed to the admission. The mother refused to be admitted because, although her illnesses were creating problems in terms of caring for her children, she was afraid that they would get no care if she were in the hospital. As the family was receiving welfare, the AC workers requested a homemaker from the Welfare Office. The AC was told that in order to qualify for a homemaker the client needed a doctor's statement, then her case would be reviewed and she would be put on a waiting list. As this was unsatisfactory, AC next enrolled the mother in the local health clinic. There she received a thorough examination, her medication was reduced, and a letter stating the immediate need for homemaker services was written to the Welfare Department. With the help of a homemaker, ongoing medical treatment, and the reduction of her medication that made the mother feel [illegible] she was physically capable of caring for her family again.

As can be seen from these case examples, the ACs did intervene on behalf of multi-problem families with little or no knowledge of how to obtain help, or how to negotiate complex health and social service systems. Such multi-problem families require an enormous input of consistent effort and dedication, because their problems are complex and require services from many different resources. In many cases these families require ongoing support and interventions the goal of making them independent in the sense that they can negotiate systems and advocate on their own behalf is simply not realistic.

5.2 Failures

- Family #1 - The AC reports that many agencies have worked with this family without success. The local hospital administrator called them of whom the mother had her fourteenth child. He described the family as one of the saddest cases he had ever seen. They AC started working with them, and the mother accepted them at first because the baby received baby food as part of a special experimental program conducted by the AC. Child Welfare threatened to remove the children and this stirred them. The family started moving and hiding. Eventually the children were removed from the home.

- Family #11 - The AC tried in numerous ways to help this family. Several appointments were made with the mother to take the children to the Health Department for their immunizations but they were never kept. When the worker came for them. Three of the outreach workers tried to help this family but were

not able to make any progress. The children and house were always dirty and smelly. On several occasions the milk in the two children's bottles was seen to be sour and dirty. Dirty clothing was often thrown everywhere, dirty Pampers were drying on the oven door, dirty dishes were all over the house and often there was no fire in the stove, despite the fact that there was wood on the porch. Tin cans, garbage, dirty Pampers, broken bottles and mess were everywhere in the yard. Neighbors, Welfare and Advocacy workers tried to find employment for the father but were unsuccessful. The AC feels that nothing was accomplished with this family.

° Family #11 - The family refused medical treatment needed by the children and would not consider family planning. There are nine living children (an addition to two deceased) ranging in age from 13 years to 18 months. The three youngest children 18 months, 2-1/2 and 3-1/2 years have had no immunizations and the mother refused to allow the AC to take them to the clinic. None of the children attend school. AC had no success in getting any help or cooperation from the Board of Education or the County Truant Officer in such cases.

° Family #12 - This is a family with seven children, the three youngest aged 1-1/2, 2-1/2 and 3-1/2 have had no shots. They refused permission to the AC to take the children for immunizations. They would not attend consumer education sessions, would not consider family planning, or any other help the AC offered. The family says that one of the children is retarded, but they refused to go for diagnosis.

° Family #13 - Child Advocacy tried to work with this mother and her four children. The children have not received any immunizations although the mother is a licensed practical nurse and they live one block from the clinic. The nurse at the clinic has even visited the home to do immunizations, but the children never completed their immunizations. The mother did not keep her apartment clean, the neighbors complained and the conditions were described as unlivéable. She did not send the children to school regularly. During one month the children were out of school for sixteen days. The school social worker stated that they talked with the mother constantly about sending the children to school. She also sent the truant officer to the home about the children. The school also took the mother before a judge in Juvenile Court, which did not accomplish anything. The mother stated that she did not have the money to give the children to ride the bus to school daily and continued to send them irregularly. After not being able to motivate this mother at all, the AC referred her to the Child Guidance Clinic for counseling, but she never followed through.

° Family #14 - The first contact with this family was through the 766 project. The goal was to make the family more aware of the importance of having their child or children screened for developmental, physical, and emotional problems. The first visit was made by two students from Tufts University. They assessed the family's needs and found that the mother and two of her children needed glasses. The AC made the second visit and registered the whole family at the Roxbury Comprehensive

Community Health Center because they had no permanent health affiliation; several appointments were made and missed. Following the screening, the child was found to have both visual and emotional problems. The problems were discussed with the mother who was told of the importance of taking him to the clinic for medical follow up. She seemed somewhat concerned at that time, but later on did not cooperate: the child was scheduled for psychological testing given by the school, but she kept the child out of school on the day of the testing. The family has since moved to New Jersey.

* Family #12 - The mother of four children did not let her children out of the house, except when she took them shopping. The oldest child did not go to school (and was not known to the school because she was never registered) because the mother was afraid that the child would be kidnapped there. The two youngest children were not immunized because the mother felt that getting to the clinic was "too much." When the AC met this family the worker tried to encourage the mother to take the child to the school which is on the same block as the family's house. The mother agreed to take the little girl to school, but said that she was afraid to leave the little ones in the house. The AC arranged for a babysitter, but the mother refused. The AC wanted to enroll two of the children in Head Start; the mother said that she would agree if the AC could get transportation. The AC made arrangements for services, but the mother refused to allow the children to go because "someone might kill them on the bus." Arrangements were made for Model

Cities bus service to take the mother and her children to the clinic. These services, like all others, were refused. While all of these referrals were being made, the family would intermittently go to Alabama and then return. Even though they always returned, the mother told the worker that there was no need to get the children settled because the family would not be staying. The AC was able to get one child to the clinic for a check-up, but despite repeated home visits, the mother still would not accept other services.

These families are representative of a whole group of families whose very low level of motivation and/or high level of pathology prevent them from accepting services. While the practices in these families can be defined as child neglect, local authorities are either too overwhelmed or too poorly trained to be able to deal with such situations.

6.0 CONCLUSION

Many of the needs identified as a function of advocacy efforts were not met. By and large the conditions of poverty remained unchanged and many needs, particularly in housing and employment remained unmet. The majority of health needs identified also remained unmet either because families could not be motivated to accept referrals or because the health needs encountered, particularly among the parents, were so massive as a function of years of neglect.

While the majority of needs identified could not be met, the majority of those referred to resources were met through

assistance on very specific issues. In many cases, AC staffs were extremely resourceful around finding and mobilizing resources to provide assistance; nevertheless, the problems were often so massive that little could be done to signficantly effect the lives of the parents and their children.

CHAPTER IV

GROUP MEETINGS

1.0 INTRODUCTION

Since the program's inception, Component staffs have encouraged family participation in AC-organized group activities. Mass meetings, workshops, ongoing group sessions and planning meetings have been held with varying degrees of regularity so that families could:

- better understand the importance and relevance of a variety of services: e.g., preventive health care, educational programs, dental care, etc.
- better understand their rights vis-a-vis service delivery systems. This includes knowledge of what services are supposed to be available through agencies such as Welfare, the Department of Housing, and the local Health Plan and how to negotiate these systems in order to obtain services.
- learn new skills helpful to them in their roles as consumers, parents, wage earners and community residents.
- have input into the direction of the Advocacy Components.
- advocate on their own for changes in the service delivery system and for the creation of new services.

At each Component, every Coordinator and staff member viewed group events as a valuable vehicle for wide-audience dissemination of information. However, at each Component, staff also voiced frustration experienced in relation to encouraging family participation, and sustaining interest and attendance. The Coordinator of an urban AC commented that, "even the Welfare Rights Organization has trouble getting people to turn out and this is an area of immediate importance to families." Rural Components cited the non-availability of transportation as a major constraint to participation. However, in urban areas where transportation was not as great a problem, and in rural areas where the ACs have provided transportation, attendance at group meetings was still relatively low. A determination is still to be made of that combination of factors which would maximize family participation even after two years' extensive, and at times innovative, effort. Comments from Coordinators seem to indicate that there is not one "package" which is effective or applicable to all Components. One urban area Coordinator felt that the best method to use in order to ensure participation was, as she termed it, the "crash approach." This entails a last minute door-to-door canvassing by outreach workers to remind families of the upcoming event and to ask them, once again, to attend. At two other urban Components, Coordinators indicated that they too had used the "crash approach" in addition to much pre-event publicity, and had even sent workers

to people's homes right before the meeting so that families would not have to arrive alone, but that these efforts did not appreciably improve attendance. Rural Coordinators felt that serving food and beverages fostered participation, while some urban Coordinators said that serving lunch and providing child care services was of no avail. Some meetings were held during the day and others were scheduled for the evening; some meetings were highly structured and others were open-ended; all meetings were planned around the expressed interests of the families, and yet participation remained a stumbling block. This is not to say that the entire family group meeting effort was a failure, indeed there were some notable, highly successful events. However, taken as a whole, the experience seems to indicate a marked discrepancy between effort and outcome.

2.0 PREPARATION TIME AND ATTENDANCE

As part of the revised Monthly Monitoring System implemented during the second year of program operation, Components were asked to submit the following information relevant to events involving more than one family:

- type of activity
- issue/topic
- overall number of families attending
- number of AC families attending
- number of activity-hours per month

- number of preparation hours/per activity in the areas of

- home visits/telephone calls
- publicity
- recruitment of speakers
- planning and information gathering
- provision of transportation for participants

The figures presented below represent averages computed on the basis of 72 different events sponsored by the ACs during the period of November, 1973 - June, 1974, inclusive.

a)	Total number of persons attending AC events	1,420
b)	Average number of persons attending	20/event
c)	Median number of persons attending	13/event
d)	Range	0*-134
e)	Total number of AC participants attending	784
f)	Average number of AC participants attending	11/event
g)	Median number of AC participants attending	7/event
h)	Range	0*-75
i)	Total number of preparation hours	943
j)	Average number of preparation hours	13/event
k)	Median number of preparation hours	10/event
l)	Range	0-73

* A meeting was called to hold elections to a PCC council. AC workers put in 12 hours or preparation time, but no-one attended the meeting. The zero is included in the range because of the preparation time involved. If this meeting were excluded, the lowest end of the range would be two persons.

Certain cautions should be exercised when viewing the "average" figures. As measures of central tendency, they are distorted by extremes which are occasioned, in turn, by wide variations in the types of programs represented. For example, "average" attendance figures include mass meetings, as well as very small "rap groups." Clearly, the average is distorted (biased) to the extent that there are not proportional numbers of each type of meeting, or to the extent that there are no "mid-sized" meetings. The same holds true with respect to the "average hours preparation" category: different types of program require very different types and amounts of preparation; the average can be highly distorted, as a result. The relatively great ranges associated with both the attendance and preparation-time figures support the need for caution in interpreting these data. Given the possibility for distortion of average values, the median values presented represent a better estimate. As would be expected, the medians for all categories are lower than the averages. This is a reflection of the numerous smaller group meetings conducted.

Approximately one-half of the persons who attended AC activities were AC families; the remaining attendees were usually PCC members, community residents, or prospective AC participants. In some rare instances, the "others" attending included agency representatives. At various points during

the AC experience, disagreements arose over the question of whether or not such events should be open to PCC families. Certain events were discontinued because the families participating were either exclusively, or in large pa PCC rather than AC families. The content of the meeting determined the extent to which persons outside of the AC attended. Large-scale events (e.g., mass meetings, workshops) that were not AC-specific in content were likely to draw outside participation and seemed to be viewed by attendees and involved agencies as "community happenings." In the case of events sponsored jointly by the AC and other community resources, or in events involving outside resources, it did not seem reasonable to limit participation to AC families.

An average of 13 hours, or a median of 10 hours, of preparation were required for each event. Thus, in terms of hours of preparation per attendee, these figures are .66 and .77 hours respectively. Preparation time does not, however, include AC staff time spent at the events, so the total number of staff hours required to produce a session were actually higher. Unfortunately, there exist no standards for comparison; there are no normative data available regarding the number of hours of preparation time in relation to the type of event or the number of individuals attending. Moreover, no criteria are available for measurement of impact on those attending.

3.0 TYPES OF EVENTS CONDUCTED

The events conducted or sponsored by the Advocacy Components represented a wide range of topic areas and utilized a number of different group techniques. Some Components "specialized" in certain types of events which had proved most successful, while other Components sponsored events which reflected an identified area of interest at a particular time. The following are illustrative of the types of activities in which Components engaged.

° Baltimore

The Baltimore AC was involved primarily in two types of events: ongoing club meetings and occasional mass meetings. Initially, responding to a need identified by another community resource, the AC organized the Teenage Mothers Club, seeking to provide service and support to teenagers who had left school due to pregnancy. Meeting weekly, the teenagers structured their own sessions with the help of an AC staff member who acted as a resource facilitator and guidance counselor. Child care and child development were discussed, as were job training programs, continuing education, family planning, drug abuse, and social activities. Fifteen of the approximately 40 members obtained summer jobs through an AC-written proposal, three mothers returned to school as full-time students, and several families were enrolled in the PCC. The teenagers were concerned about the future of their club after AC termination.

This concern was shared by the AC and PCC staff members, who searched for a resource to take on the function of club sponsor. At the time of this writing, no sponsor has been found although the PCC was giving serious thought to incorporating the group into their program.

In terms of pure meetings (which occur only once and do not become an ongoing group activity), the Baltimore AC has, like all other Components, been highly successful with some events and less so with others. Because their catchment area was defined as a public housing project with community space, this AC was in a particularly fortunate position, geographically, to draw large audiences: events could be held in the family-" building complex, and "the problems of transportation and anxiety induced by having to go to a "new territory" were virtually eliminated. Using their community space, the project has sponsored meetings on such topics as drug abuse, family planning, literature for black children, and employment opportunities/job training programs. In addition, they arranged and sponsored a workshop aimed at introducing the Welfare Department structure to the community. While many families knew and used the Welfare Department, few really bothered to understand how and why decisions were made or just what Welfare helped like "at the top." The Assistant Manager of the Welfare Department was the main speaker. He provided prepared information and then accepted questions and comments from the audience. In reply to someone's

complaint about treatment received from a DSS worker, the District Manager made it clear that what had happened was not what was "supposed" to happen and requested that anyone who had such problems contact him. The AC Coordinator mentioned to CCR staff that after the workshop, people had a better feeling about Welfare's intentions, and that they just might call the District Manager when they have a problem.

° Boston

The Boston AC began a series of group events early in their history. During the first program year, two series were begun: pre-natal care classes and a weekly luncheon meeting. The former, conducted by the Health Advocate, were continuously troubled by poor attendance. Started with only three or four women, the group size grew at one point to thirteen. However, as group members began to have their babies, new expectant mothers did not join, attendance dropped back to two or three women per session and the classes were ultimately discontinued.

The weekly luncheon meetings faced a different set of problems. These meetings, open to AC and PCC families, were held at the PCC every Monday afternoon and were chaired either by resource persons from other agencies or by AC staff. Meeting topics emerged from participant discussion, and included such topics as housing, Welfare rights, day care, education, medical areas, and drugs. However, even though

the topics were self-generated, and lunch, transportation, and child care services were provided, attendance by AC families was low. PCC family participation was somewhat higher as these persons were, for the most part, already at the Center. While attendance did improve somewhat toward the start of the second year, the ratio of AC to PCC families remained skewed. Due to this imbalance, the meetings were discontinued.

While these meetings were being phased-out, the Advocacy Component became involved in what is termed the "766" demonstration project, and family group events took on a new focus.

The 766 Project was chaired by the Alliance for Coordinated Services and involved several agencies within the community, among them the AC. The State of Massachusetts passed the Special Education or 766 Law requiring the assessment of all children ages 4-21 and the development of an educational plan for each individual, based on the assessment. The Law, due for implementation in September, 1974, was new to the school system, where it generated much concern as to the feasibility of effectively implementing its mandates. It was with the idea of developing a model for implementation that the Alliance took on the coordination of the 766 Project. In concert with a representative from the Community Health Services Division of a local hospital, the Alliance began to consider the areas in which assessment would be undertaken:

social, developmental, medical, dental, cognitive, educational, sight and hearing. Both the hospital representative and the Alliance agreed that, as the schools would be responsible for implementing the law, the schools should be looked to for provision of personnel for the demonstration. Thus the first step was to choose a demonstration school. After rejecting one school on the basis of its principal's lack of enthusiasm for the project, a school close to the AC was chosen. The original demonstration plan called for the use of the school's nurse, physician and guidance counselors, but interviews with various school and district personnel proved this plan unfeasible. Therefore, it was decided that the hospital, a medical/dental service, and a retired Navy nurse would carry out the health-related portions of the screening/assessment and that the AC would carry out the social screening. Some of the agencies involved in the Project at this time were aware of the Component's capabilities and had recommended the AC to the Alliance. It was decided that Advocacy staff would be responsible for: (1) home visiting all families of demonstration children for the purposes of identifying unmet needs and assessing the home environment; (2) informing families of screening appointments and facilitating their attendance at appointments; (3) effecting whatever referrals to other agencies were made by the screening/evaluation teams.

According to the demonstration plan, AC staff members were the first agency representatives (excluding school

personnel) to make contact with the children and their families. Building on this position, the AC took the lead in planning and conducting group meetings for the 766/AC families. While these meetings were similar in nature to the discontinued luncheon sessions, attendance was much higher. The AC Coordinator attributed this increase in participation to two factors: the increased sophistication of the staff and the fact that the 766 families represented an already identified population to whom the AC could offer a "concrete" service, e.g., a linkage with the school system that promised results. One indication of success involves the turnout of "766" families at a medical screening: of the 60 children who were to be screened, 58 mothers accompanied their children. Moreover, an average of 53 persons attended each of the AC conducted "766" meetings.

° Cleveland

During most of its period of operation, the Cleveland Advocacy Component did not direct a major portion of staff energies to family group events. While several meetings were held, no ongoing groups or committees were formed. As efforts to conduct sessions were frustrated by poor attendance, attention turned to other methods for accomplishing the goals of group meetings. However, two events reversed this orientation: (1) the addition of a caseworker counselor and a homemaker to the AC staff and, (2) the initiation of a "housing demonstration project."

In the middle of the second program year, negotiations between the AC and its delegate agency resulted in the deployment of a caseworker and a homemaker to the AC staff. After receiving appropriate referrals from the outreach staff, these workers began to organize small group sessions. While these groups were being formed, the Component drew up plans to begin another group project - the Housing Demonstration Project, which would implement some of the recommendations made in the AC's Housing Report. This demonstration called for the coordination of various community agencies in an effort to install human services within a neighborhood housing project. The AC's goals included the provision of social and recreational services through the active participation of the housing residents. In order to explain the demonstration and to set in motion the organizational processes needed for a successful demonstration, the AC first conducted a housing workshop and then subsequently developed, with resident input, group sessions chaired by the AC homemaker. Attendance at these events was higher than had been manifest at previous group meetings. This "success" appears to again illustrate that group meetings are best received when the sponsor can offer something "tangible" in return for participation, and that improved attendance results when meetings are held within the attendees' home base.

° Huntington

During the second program year of Advocacy, a new project was introduced into the Component's catchment area, "Teenagers As Child Advocates" (TACA), sponsored by Southwestern Community Action Council, Inc. and Save the Children Federation (SCF). TACA has the aim of teaching high school students the basics of child care, child development, and psychology.

Twenty-five teenagers received high school credit for classroom instruction in this subject. In addition, five hours per week were spent working with a total of 91 children from Advocacy families. Each teenager was paid $1.00 per hour for the home visits. Both teenagers and AC children were recruited by Advocacy outreach workers after the program was presented to AC staff members by a representative from SCF.

During the summer months, teenagers were introduced to the pre-schoolers with whom they would work. In August, a training schedule was instituted, consisting of films and lectures. Also during August, TACA students observed and discussed the child care techniques used in the Harts Parent-Child Center. At another session, the students interacted with children at the PCC and later saw this interaction on videotape. First home visits were made at the end of August and a follow-up group meeting was held to discuss the experience.

Throughout the fall and winter months, various workshops were held to discuss child learning and development, use of

first aid, and other relevant topics. Meetings were also held with the parents of the preschoolers to keep them informed of the progress of the project.

The first TACA year ended in May, 1974. Twenty-one students received certificates of recognition along with high school credit. Recruitment was begun by AC staff for teenagers to participate in the second year of the program. In addition, fourteen of the first group of students will be retained in the program for further experience. Besides affecting the lives of the teenagers and preschoolers who participated in the program the first year, the TACA program will be built into the Home Economics Curriculum of the high school after outside funding ends.

Advocacy families also met and interacted through AC consumer education programs. Eighteen different classes were held in the period from November, 1973 through June, 1974. Classes were held in various community facilities within the AC catchment area. Advocacy staff, primarily the nurse and nutritionist, discussed topics of interest to the families such as first aid, canning, dental care, food preparation, food buying, and drug and alcohol abuse.

The Huntington Advocacy Component has had an average of eighteen AC families attending each such activity. While there has always been a problem in this rural area of attracting families to such events, the consumer education classes are becoming established in the community.

° Jacksonville

Family group events took several forms at the Jacksonville Advocacy Component. At the beginning of program operations, the AC conducted rap sessions around the major AC areas of concern: pre-natal care, immunizations, well-baby check-ups, family planning and child problems. These sessions were used primarily as sounding boards, allowing participating families to have a say in the direction of the project. In addition, rap sessions served as a vehicle to facilitate socialization and problem sharing among AC families. With the exception of a teenagers' group concerned with family planning, these sessions did not develop into ongoing groups. However, as the AC continued to grow and change emphasis, so did the program of family group events. In terms of large-scale or mass events, the Jacksonville AC has been highly effective in sponsoring sickle-cell testing clinics. During the period from November, 1973 to July, 1974, the AC sponsored three such clinics, administering tests to a total of 231 persons. When the Component took an active role in securing legislation for day care center licensing, it held a letter writing workshop attended by 25 persons. The AC followed this up by recruiting 15 AC participants to collect signatures for a petition; 385 signatures were obtained in the catchment area. Small group meetings were also conducted which involved AC families in the planning and execution of a Patients' Rights Handbook. Thus, while no ongoing groups developed, family group events were conducted in order to involve and to educate families in those particular areas to which the Component was directing its efforts.

If group activities are seen as a means of educating families to the resources and issues that impinge on their lives, then the Information Center efforts of this AC should be considered a quasi-form of family group events. Each Advocacy Component devised mechanisms for disseminating important information to its participating families, e.g., resource directories, telephone information stickers, a hot line. The Jacksonville AC combined several of these mechanisms by developing Community Information Centers. Five such Centers were created throughout the catchment area, consisting of easily accessible boxes containing resource guides, AC-related materials and announcement bulletins for relevant community events.

° Leitchfield

Activities involving groups of families have not been a major part of this Component's efforts. It has always been difficult to attract people to group meetings and provide transportation. Nevertheless, several attempts were made to organize family group events. Attendance at these events has ranged from seven to nineteen AC families.

Four different meetings were held during the period from November, 1973 through June, 1974. Classes dealing with nutrition were held twice by the PCC/AC Nutritionist. Discussions centered around proper foods and food preparation. The PCC/AC nurse led one session on health; the Extension Office was invited by the AC to discuss gardening and how to set up a garden with AC families.

4.0 CONCLUSIONS

Since no interviews with families attending AC meetings were conducted, it is virtually impossible to assess the impact on families of this particular aspect of the AC effort. In general, it can be said that attendance at most meetings was less than expected and sustained participation was rarely achieved. Despite these difficulties and disappointments, most Coordinators expressed the feeling that such meetings are an important mechanism for consciousness raising in the community but that achievement of this goal requires many years of sustained effort. Therefore, unless a directed effort is made over a long period of time, there is no way of knowing what the eventual impact of such an approach could be.

CHAPTER V

RELATIONSHIPS WITH OTHER AGENCIES

1.0 INTRODUCTION

All of the Advocacy Components developed and maintained extensive linkages with other agencies. Analysis of staff time data shows that on the average, 11% of total staff time was spent in agency related activities, i.e., identification of resources and establishing and maintaining cooperative relationships. Components varied considerably in this respect, however, the range is from an average of 3% at one urban Component to an average of 16% at a rural Component. These averages are based on total staff time and do not include a breakdown according to staff position. As will be seen in Chapter VI on staffing of the ACs, in most Components coordinators spent the major portion of their time in agency-related activities whereas outreach staff spent considerably less, if any, such time.

Information on AC-agency relationships was obtained from two perspectives: monthly reports on agency-related activities from the ACs themselves and interviews at a sample of agencies in each community.

As described in Chapter I, CCR received the following information from each Component on a monthly basis:

- Number and type of new agencies identified
- Number and type of linkages or projects explored or established

- Number and purpose of inter-agency meetings
- Report of all new services or changes in agency practice, procedure, or eligibility as a result of AC intervention.

In addition, during the first evaluation year, CCR staff visited approximately five agencies in each community both at the beginning (T1) and at the end (T2) of the year. During the second year, visits to agencies were made toward the end of the evaluation period (T3). Originally, the ACs were asked to identify those agencies with which they intended to work most closely during the two-year period. Many of the agencies visited at T1 were not, ultimately, those agencies with which the closest collaborative relationships were established. Therefore, at T2, CCR staff revisited some agencies, but made visits to agencies not seen during T1 site visits. By T3, collaborative relationships had been established with many different agencies, particularly in the urban areas. Tabulated below are the number of agencies visited once, twice, and three times.

Table V-1. Frequency of agency visits.

AGENCIES VISITED ONCE	AGENCIES VISITED TWICE	AGENCIES VISITED THREE TIMES
25	18	13

Fifty-six different agencies were visited for a total of 100 agency interviews. As can be seen below, interviews conducted at health agencies and at welfare agencies accounted for almost three-fourths of all interviews.

Table V-2. Number of interviews at various types of agencies.

HEALTH	WELFARE	LEGAL	EDUCA-TION	COMMUNITY SERVICE	EMPLOY-MENT	HOUSING
46	23	11	8	7	3	2

Information presented in this chapter is based on the AC monthly reports and on these agency interviews.

2.0 IDENTIFICATION

Stemming from the ACs' mandate to identify the gaps in existing services and to function as a coordinating mechanism for referrals, identification of agencies and services has been a major activity at all ACs. In order to make appropriate referrals, staff needed to fully understand the services available at each agency; in order to identify service gaps it was first necessary to find out what exists in the community. While the process of identification was complex and time consuming, the results constitute a major area of AC achievement.

Identification was most often accomplished through AC-agency meetings. During the first year, the AC Coordinator was the person who most frequently arranged and attended these initial meetings. Although work with agencies remained

a major aspect of Coordinators' job descriptions, at most ACs agency identification soon became the responsibility of other staff members as well. In its most common form, the process entailed a personal meeting during which the AC and its concepts were introduced to the agency, and the AC representative obtained detailed information on the services offered by the agency: eligibility requirements, procedures for obtaining services, and staff functions within the organization. One major indicator of success is the fact that all of the ACs identified many agencies and resources previously unknown to the already-established PCCs. In this respect, the Components became a valuable resource to PCC staff in their efforts to obtain services for PCC families.

Another indicator of AC success in this area is the fact that several agency administrators, interviewed by CCR, reported that the Advocacy Components were one of the few, if not the only, organization in the community with a broad knowledge of agencies in different service areas. While it is not unusual for a health agency to be aware of other health-related services in the community, administrators pointed out that it is uncommon for agencies to be familiar with resources outside of their specific service fields. ACs, however, became knowledgeable in a variety of service areas, and as such were often asked by agencies to act as an information resource when services not within an agency's specific content area were needed.

The most concrete result of AC identification efforts was the publication of community resource directories. Four Components produced Agency Directories, three of which were designed specifically for use by service consumers. The fourth Directory was rather complex and was suited for use by AC and community agency staffs. Directories listed the names, addresses, telephone numbers and service offerings of all agencies identified. Where appropriate, eligibility requirements and hours of operation were also included. Three of the Directories were compiled and distributed during the first year of project operation while the remaining one was completed during the second Advocacy year. The two Components that did not formally publish Directories did, however, maintain comprehensive files on agencies for in-house use.

While the major work of agency identification was completed during the start-up year, the process was ongoing throughout the life of the project. During the second project year, the identification of new agencies was less frequent; instead, new service elements of already-identified agencies were explored . For example, while the AC may have identified the Health Department early in the process, close contact with and knowledge of the Family Planning Division may not have occurred until the second Advocacy year. During this second year, an average total of between six and eight agencies or services within agencies was identified by the six Components each month.

3.0 LINKAGES/RELATIONSHIPS BETWEEN INDIVIDUAL AGENCIES AND THE AC

Once an agency was identified by an Advocacy Component, the next step was to develop a working relationship. The nature and purpose of the relationships or linkages established was dependent upon both individual AC style and the particular agency involved. While a variety of relationships were developed with a large number of agencies, linkages were most often based upon:

- referral, or
- exchange of service elements, or
- community and/or agency planning, coordination or change, or
- a combination of the above

3.1 Referral-based relationships

The largest proportion of AC-agency relationships were operationalized in terms of referral activity. Twenty of the 37 agencies at which CCR conducted interviews at the end of the first year indicated that a referral linkage was the sole ongoing basis of relationship between the agency and the Component. The same interpretation is not meaningful with respect to T3 interviews, because T3 agency selection was made, generally, on the basis of a more specialized and expanded relationship with the AC. In fact, review of responses from administrators interivewed at T3 shows that

the majority of these AC-agency relationships had been expanded so as to encompass a broader range of mutual activities.

However, while the expansion of relationships was true for those agencies at which CCR conducted interviews, there is neither evidence nor reason to assume that the majority of other AC-agency relationships were, at the time of project termination, based on something other than a referral linkage. In fact, a referral linkage was most often the necessary base from which to accomplish an important aspect of AC operations.

The referral linkage was usually one way: the AC referred clients to the agencies. However, there were also numerous instances in which agencies referred clients to the AC for further service referral. As noted earlier, this occurred as resources became aware of the extensive agency identification efforts of the Advocacy Components. Of the 30 interviews conducted with agency staff at the end of year two, 11 interviewees reported that their organization referred clients to the AC. At least one agency in each AC community referred clients to the respective AC. Usually such referrals occurred when the agency did not have the resources to help the client and hoped that the AC would either be able to make an appropriate referral or would provide the agency with assistance in the servicing of that client. Some

administrators stated that a number of their referrals to AC were based on their impression that the AC staff had better rapport with many families, as well as a follow-up capability. This type of exchange speaks to the Components' visibility and credibility within the service delivery network.

3.2 Relationships based on an exchange of services

3.2.1 Outreach on behalf of other agencies

During the course of the project, each Component performed some type of outreach function either within or on behalf of other agencies in their respective catchment areas. In all cases, the desired outcome of this cooperation was the same, i.e., the facilitation of service delivery procedures. However, the origins of the arrangements often differed. In some instances, particularly at the start of AC operation, it was the AC staff which offered its services to the receiving agencies, often in an effort to gain credibility for the project or to ease the way for future demands that the AC would place upon the agency. In other cases the agencies approached the Components, often because agency administrators believed AC staff to have better rapport with client families or because the AC had a field capability which the agency lacked. Such arrangements were mutually beneficial to both organizations, as well as to the target population. The community agencies received a service,

while the Components gained acceptance and visibility. In some cases, the services performed by the ACs also provided them with something "tangible" to present to new Advocacy families or to motivate ongoing families.

- In Baltimore, workers from the City Department of Social Services used the AC outreach workers to assess eligibility for furniture grants. This was not done as a matter of DSS policy, but rather as a function of relationships developed between the DSS and AC staff. Such utilization of the Component eased DSS staff demands, cut down on the time elapsed between families' application and receipt of grants, and helped to create a reputation of AC efficiency and usefulness among community residents.

- The Hough Advocacy staff provided outreach services for the major health facility in the catchment area. An AC worker called all families who had an appointment for the following day to remind them or to encourage them to come. While this practice was discontinued during the first project year, AC workers did continue to register appropriate families for the clinic's services as part of the assessment process.

- Both the County Welfare Departments and the County Health Departments sometimes relied on Huntington AC workers to assess individual family needs. The AC was located in the catchment area, whereas the Departments were approximately 25 miles away. Thus in emergency situations, particularly when the weather made the roads impassable, the AC could facilitate service delivery. Administrators interviewed stated that the AC's outreach capability was of tremendous importance both because of their proximity to the target area and because of the close rapport developed between AC outreach workers and AC families.

- The Huntington AC identified and recruited mentally retarded children for a new program of special education for the mentally retarded.

- During the life of the project, Jacksonville Advocacy workers directed their efforts toward facilitating procedures at the local hospital. Because the registration process was complex and time consuming, workers sought permission to perform this procedure for their families. While this plan was never accepted, the Component was able to make the process more comprehensible to clients. AC staff members posted information

sheets throughout the hospital so that patients would be informed of all materials needed for registration and subsequent treatment. Through a widespread outreach campaign, they made hospital procedure information available to the target population. Perhaps the greatest gain in this area was the compilation of a Patients' Handbook which will be discussed in greater detail elsewhere in this chapter.

- In Leitchfield, the AC offered transportation to families served by other agencies, often in conjunction with other AC planned trips to resources. This was the best known and most highly valued activity of the AC among agencies interviewed in this community where transportation presents a major difficulty to agencies and families alike.

3.2.2 Use of community agency's staff as resources for AC staff training or for AC-sponsored community workshops

During the first project year, the Components developed linkages with agencies that provided training for AC staff, as well as staff and information for AC-sponsored community meetings and workshops. In several AC communities, such exchanges represented the first time that various agencies became involved in the organization of another neighborhood resource. Some agencies conducted staff training sessions during which agency procedures, policies and requirements

were detailed, while others trained AC staff in skill areas, e.g., interviewing, information gathering, techniques for follow-up, etc. In the cases of AC-sponsored community meetings and workshops, agencies provided materials for distribution, helped in the planning of content and/or sent representatives to make presentations. Training and workshop involvement came from such varied resources as Welfare Departments, universities, Legal Aid, County and City Health Departments, settlement houses, Planned Parenthood, public housing agencies, Welfare Rights Organizations, drug education programs, and child guidance clinics. As each agency offered its assistance or was recruited by the AC for involvement in a project, Component staffs would report these instances to CCR in detail.

During the second year of AC operation, such linkages continued and expanded, but received less emphasis in terms of reporting, from AC staffs. In a sense, agency involvement in AC training and workshops came "to be taken for granted." That is, after the initial foundations and linkages were established, this continued exchange came to represent the way in which an ongoing relationship should be operationalized and, as such, was accepted into the ongoing pattern of AC training and workshops.

3.2.3 Advocacy on behalf of other agencies

In La Junta, agencies reported that the AC had acted on their behalf to elicit public support for agency activities

during the first year of AC operation. The failure of the other ACs to act on behalf of other agencies may be attributed, in part, to the "newness" of the projects. That is, in order for a project to advocate on behalf of another agency, it is necessary that this project have a substantial "power base" from which to draw support. This power base, built upon contacts within the service network and relationships with community residents requires time to develop. Thus, it seems likely that during the first year of operations, the ACs could not effectively lend support to another agency as they themselves were in the process of gaining their own support.

As the projects moved into and completed their second year, they were asked to participate in the functions of other agencies. This increased acceptance can be measured in terms of AC involvement in interagency councils, participation of AC staff on the Boards of other agencies, and in their ability to support other agencies when the need for such support arose. The following are examples of such activities:

- The Welfare Rights Organizations (WRO) in the Cleveland community was working to obtain Welfare clothing grants for Head Start children. While the policy seemed to be "on the books", it was not being implemented. When WRO and the AC worked together, the Component used its agency

contacts and community support to build public pressure to help the policy gain full implementation.

- The Cleveland AC was asked by concerned community residents and organizations to take a leadership role in convincing a council to plan strategy around the proposed closing of the local County Welfare Office.

- The Leitchfield AC, located in an area lacking adequate health care facilities, lobbied for the approval of a hospital bond issue. Staff members and AC families worked with the health department in one county to publicize the need for building an addition on to the hospital. The issue was approved by the community.

- This same Component also lobbied in the courts on behalf of the health department in another county, which was in jeopardy of losing funding.

4.0 CHANGES IN AGENCY POLICIES AND PROCEDURES AS A FUNCTION OF ADVOCACY EFFORTS

During the two years of the demonstration much has been learned about the ways in which agencies operate and the capacity of agencies to implement changes. The somewhat idealistic hopes of the first few months of AC operations

were tempered by growing Component awareness of agency constraints to change. In the process of building working relationships with agencies, Coordinators and staffs came to realize that many agency problems were not unknown to agency administrators. It also became apparent to Coordinators that influence over change agents was beyond the reach of both administrators and Component staffs.

In most cases, the greatest constraint to change was mandated at the federal or state level, through legislation, regulation, or guidelines. A change in policy, or for that matter even procedure, entailed, in these cases, a process well beyond the grasp of AC staff. Even in cases where the desired change did not conflict with government regulations and guidelines, it was often impossible to fully effect change due to agency shortages of staff or funds. While some Component staffs came to realize that legislation was often the only key to change, and while some ACs did significantly effect legislation, this time-consuming and complex process could not be initiated at most ACs given the nature of responsibilities, and time frame of the projects. In those instances where legislation was drafted as a result of AC intervention, the efforts represent landmarks in the operation of the projects and a significant move in a shift from case to class advocacy.

Recognizing the constraints, most of the Components concentrated on building relationships and working with

individual agencies in mutual efforts to maximize the service potential of the agency within the existing agency structure. Where close working relationships at the administrative or line staff level developed, the ACs functioned as an overall watchdog or monitor ensuring that existing policies were fully implemented and that services were delivered as effectively as possible. A few administrators reported that the AC had brought abuses, in terms of staff negligence or insensitivity, to their attention. While such monitoring efforts did not change policy, they did improve the level of service delivery. Interviews with AC Coordinators indicated that many considered their efforts to sensitize agencies, and to make them more responsive to client needs, as one of the major successes of the Advocacy project.

The following are illustrative of the kinds of changes the ACs effected both within the service delivery system and the legislative process:

- In the Boston community, certain procedural changes have occurred in the Obstetrics-Gynecology Clinic of the city hospital as a result of AC intervention. Whereas previously a pregnant woman was seen by a different doctor at each visit, currently a pregnant mother is introduced to a team of three doctors and one nurse. One member of this team is always available to do the pre-natal check-ups and the actual

delivery. Thus, the shift was from impersonal, faceless care to a group practice type of arrangement. In addition, a system was introduced which allows pregnant women to receive not only pre-natal check-ups, but also pre-natal education. Women are scheduled in groups of eight for two-hour periods. Two such groups are scheduled for the same two-hour period. In this manner, one group receives its pre-natal check-ups while the other participates in an educational session; the second hour the groups are reversed.

- During the first project year, each outreach worker from the Boston AC spent three hours per week in the emergency room of Boston Children's Hospital as Patient Advocates. This was part of an eight-week demonstration project aimed at (1) improving patients' understanding of the hospital and its procedures; (2) increasing patient awareness of the need for preventive medical area; and (3) sensitizing hospital personnel to the non-medical needs of the client population. This demonstration, undertaken as a result of AC input, led to the permanent implementation of a patient advocacy program in the facility.

- The Cleveland Advocacy Component used its delegate agency, the Center for Human Services (CHS) as a referral resource for counseling and homemaking

services. As in other communities, clients often did not feel comfortable in the "downtown environment" and the incidence of missed appointments, even with AC encouragement and assistance, was high. To counteract this problem, the AC negotiated a decentralization plan with the Center. The plan, the result of AC documentation of need in the form of case vignettes, permitted the deployment of a casework counselor and a homemaker to the Component on a part-time basis. AC outreach staff referred appropriate families to the CHS workers and within a few weeks both CHS persons were handling full, actively participating caseloads. This experiment resulted in CHS preparations to decentralize additional staff members through deployment to other community service organizations.

- The Cleveland AC obtained a cost reduction in adult education classes for welfare mothers.

- Cleveland AC staff thoroughly documented housing conditions within the AC catchment area. The report contained case vignettes, correspondence with individuals and agencies charged with housing administration, and extensive photographic evidence of poor housing conditions. The report was widely distributed and received the attention of several

influential persons, among them U.S. Representative Louis Stokes. Congressman Stokes met with the AC Coordinator and, as a direct result of this meeting and the Component's report, drafted the Stokes Amendment to the housing bill then being considered in the U.S. House of Representatives. The Amendment called for the use of quality construction materials, a factor emphasized in the AC report, but heretofore not considered by legislators nor agency personnel.

- Agencies located in Huntington have become more responsive to the outlying rural areas served by the PCC/AC.

- Clinics in the two counties served by the Huntington AC are providing services on a sliding scale fee basis, not previously available.

- Funds for health services to the medically indigent have been made available through a social-medical services foundation.

- As a result of AC-agency negotiations, the Jacksonville City Health Department has extended its hours of service from one three-hour day per month to one three-, and one eight-, hour day per month. In addition, during the second AC project year, the City Health Clinics agreed to extend their primary care services.

- Jacksonville Advocacy Component efforts resulted in an increase of Medicaid service providers within the community. Prior to AC intervention, Jacksonville's dentists would not accept Medicaid payment for services, thus making dental care inaccessible to many families. AC staff met with local dental societies and undertook a campaign to inform residents of the situation and gain grass roots support. As a result, the dental community agreed to accept Medicaid payment for examinations and treatment of Head Start children.

- The staff of the Jacksonville Advocacy Component was actively involved in the coordination, planning, and actions of the multi-agency Child Care Coalition. In part, through AC agency contacts and lobbying efforts, the group was able to facilitate the drafting and acceptance of improved day care licensing legislation.

- Through planning with Leitchfield AC staff members and other local agencies, one rural county health department has added the position of a family planning outreach worker to its staff.

- The Leitchfield AC persuaded several clinics and hospitals to make later appointment hours for families from the catchment area, thus allowing for the 50 mile drive to the resources.

5.0 FILLING GAPS IN SERVICES AVAILABLE THROUGH STIMULATING THE CREATION OF NEW RESOURCES OR THROUGH SUBSIDIZING EXISTING AGENCIES TO PROVIDE NEW SERVICES

When the Advocacy Components were implemented, most staff members were indigenous, and therefore aware of existing service gaps and deficiencies. Thus, formal identification of services and gaps often served primarily as a validation process. However, developing the capability to act upon this information presented a whole set of different problems. The mechanisms that had to be set in motion in order to fill a gap in services were complex, often included several agencies, and usually involved a considerable expenditure of time. Once a gap was identified, it was necessary to mobilize all relevant community persons and agencies to work on the creation of a new resource, to find a funding source or sources and then to follow the service to the point of full implementation. Clearly, given these tasks, it was unrealistic to expect that new services would be developed during the first project year; thus, it is particularly noteworthy that several new resources were in place at the close of the Advocacy demonstration. Some of the gains made in this area are as follows:

- The Cleveland Advocacy Component negotiated with their delegate agency in an effort to continue the Component's activities after the termination of federal funding. The agency has agreed to continue the Hough project at a somewhat lesser

funding level and is considering the creation of a central Advocate position within the agency and the expansion of Components, along the PCC/AC model, throughout the city.

- One outstanding effort to create a new resource has actually been realized in a rural community. The Huntington PCC/AC served two counties, both of which had major gaps in health care services. One of the counties with a population of 35,000 has one Public Health Doctor and two Public Health Nurses. The other county, population 18,000, has one doctor and one nurse. Both doctors are located 25 miles from the catchment area. Months of meetings and "consciousness-raising" through newspaper coverage was devoted to securing certification of need for a clinic in each county. Following this, both local, private non-profit, and federal resources were mobilized by the AC and the local CAP, in order to provide necessary money and personnel. As a final result, two clinics are operational and staffed by National Health Services Corps. Each clinic is staffed by a physician, dentist, nurse, lab technician, pharmacist, and clerical personnel. One physician is extending his placement at the clinic; the other will begin private practice in the county after his NHSC term has ended.

- One county, of this same Component, had funds available to hire a sanitation officer but had left the position vacant. Through efforts of the AC Coordinator and AC referrals to the county, this position was finally filled.

- As noted elsewhere in this report, the Huntington AC developed a program to train teenagers as Child Advocates (TACA). Twenty-five high school students were recruited to work with AC children as part of a home-based child development program. The teenagers spent time in the classroom receiving instruction and guidance in child development after which they worked with AC children in their own homes. The students earned high school credit for this training and were paid a salary for their time in the field, as well. On-the-job training was also given at the PCC/AC. While TACA was funded by Save the Children Federation for a three-year period, it has also been built into the high school curriculum so that it may continue after present funding ends.

- The Jacksonville AC identified a gap in services to blind children. The Component persuaded the Bureau of Blind Services to establish a pre-school program for blind children which operates for three hours per week.

- The Leitchfield Advocacy Component used some of its funds to subsidize two County Health Departments to perform examinations for children 0-5 years. Prior to this subsidization, the Health Department did not, due to a lack of funds, provide services for this age group.

- One rural county served by the Leitchfield AC lacked special education classes in its public schools. The Advocacy Component, with other local agencies, tried to organize such classes in the school, but were told that a special agency had to be created. Advocacy, other health and education agencies, and private citizens, organized the Breckenridge County Educational Association for the Handicapped. A membership drive was launched and money was raised at the county fair. As a result of interagency cooperation and Advocacy efforts, by both staff and families, special education classes will be instituted, with teachers' salaries paid by the Association.

6.0 INTERAGENCY COORDINATION

In an effort to achieve the goal of "bringing together a comprehensive and efficient delivery system of services," and in the service of maintaining a working knowledge of all relevant activities within the community of agencies, AC staffs

actively participated in a number of inter-agency meetings and councils, and on the Boards of various community agencies. While the majority of meetings were convened between the AC and one or two other agencies for the purpose of working around an agency or case specific problem, coordination took other forms as well. At two ACs, Boston and Leitchfield, Component staffs, during the first months of operation, organized ongoing inter-agency councils which met regularly to exchange information, coordinate efforts and generate new ideas. At these and other Components, staff members were also regular participants at meetings conducted by other agencies. Often, either as a result of involvement in other agency meetings, or because of a specialized interest on the part of the AC, staff members convened or participated in consortiums usually composed of agencies from similar service areas or with similar foci. As would be expected, this type of involvement was more common during the second AC year when priorities were more clearly defined than during the start-up year.

It is clear that a great deal of time and energy was devoted to inter-agency coordination; no matter what the mechanism used. Data from the Monthly Monitoring Report show that AC staff attended at least one inter-agency meeting each month. Although at one Component a record number of 36 meetings were attended during a single month, the average number of meetings for a single Component was 7 per month.

The range in terms of the number of meetings per month for any single component is 0-36.

6.1 Inter-agency councils

The following are brief descriptions of the two AC efforts directed toward convening inter-agency councils:

- At the start of project operations, the Boston Advocacy Component formed three Ad Hoc Committees addressed to the topics of health, education, and welfare, respectively. Each committee met with staff members of relevant agencies once a month, in order to exchange information and share new ideas. These committees met regularly throughout the first year. During the second project year, as the AC became more involved in specific issues, the Ad Hoc Committees met less regularly as a body, while some of the member agencies were incorporated into other AC-sponsored meetings. With the termination of the Advocacy Component, a multi-service organization in the community has agreed to convene regularly scheduled inter-agency meetings.

- In Leitchfield, the AC sponsored a County-Wide Inter-Agency Meeting in each of the two counties comprising its catchment area. All of the social service and health agencies in the county met every other month to exchange information. A significant

outcome of these meetings was the decision by member agencies to share transportation facilities. These meetings were ongoing throughout the life of the Component. However, the AC Coordinator indicated that the continuation of these meetings upon termination of the Component was doubtful as no agency had, at the time of this writing, offered to act as host, nor had the member agencies expressed a strong desire to maintain such structured contact.

6.2 Coordination around specific issues/linking agencies with one another

While the maintenance of inter-agency councils and ongoing meetings among all relevant agencies was not part of the design of every Component, the ACs facilitated other community cooperative planning efforts.

- The Baltimore AC sponsored a meeting between the Department of Housing and the Department of Social Services in order to effect coordination between the two. At that time, the Department of Housing was planning to institute its own social services program which appeared to partially duplicate the services of the DSS. However, despite the ACs coordinating efforts, the Housing program was installed.

- In response to the predicted shortage of fuel, the Boston Advocacy Component coordinated a Coalition on the Energy Crisis. Member agencies included those which had bearing on families' lives in the areas of health, housing, welfare, and education. Local political leaders and state and city officials were invited to meetings, and were kept aware, in ongoing fashion, of all Coalition proposals and strategies. Representatives of the Coalition brought issues to the attention of their service populations and massive letter writing campaigns were undertaken to make persons in power aware of the needs of the low-income community.

- Perhaps the most significant action undertaken by the Boston AC during its second year of operation was its involvement in the "766 Project." This Project, a demonstration program for implementation of the State Special Education Law (766), drew upon the services of health, education, psychological, and social service agencies. Coordination of the Project was undertaken by an independent coordinating agency which, at the suggestion of other resources involved in the Project, invited the AC to lead the efforts in the social service portion of the demonstration. In this capacity, the Boston AC assessed families, wrote individual case histories

and case plans for each family, recommended appropriate referrals, followed up referrals, and participated in evaluation case conferences with all other consortium agencies. During interviews with representatives of consortium agencies, each expressed full knowledge of and appreciation for the services performed by the Component. In fact, the principal of the school in which the 766 demonstration took place stated that the AC was "a Godsend to the school - if I could get the money I'd take the whole program as a unit into my school."

A major effort of the Cleveland Advocacy Component during its second year was the implementation of a Housing Study. After completing the Study and widely disseminating the findings, the AC took the lead in coordinating the resources of neighborhood agencies in order to mount a demonstration project involving the provision of social services within a community housing project. The project involved resident participation, recreational activities, homemaking and counseling. The AC coordinated all of these services, installed the demonstration and made provisions for the evaluation of impact.

- The Huntington PCC/AC was involved in the planning of a laundromat in its rural catchment area. A university professor assigned his students the task of surveying the desires of community residents. A laundromat was most often mentioned and several agencies are now meeting to accomplish this objective.

- An elementary school in the catchment area of the Huntington AC was badly in need of sewer repair. PCC/AC efforts to make this problem known led to the County Board of Education members asking to meet with PCC/AC families to resolve this problem.

7.0 HOW THE AGENCIES VIEW THE ADVOCACY COMPONENTS

Most of the agency administrators interviewed indicated that they felt that the Advocacy staff in the community had carried out extremely important and necessary functions. The areas mentioned can be categorized as follows:

- Outreach

  Almost all administrators described the AC outreach function as a particularly important aspect of the AC capability. Informing and encouraging families to use available resources and conducting regular follow-up visits were unanimously recognized as a crucial function.

- Needs assessment

  Most administrators were unaware of the AC needs

assessment effort, other than in the most general terms. It was usually described by administrators only as providing a vehicle for making necessary referrals. Few of them viewed this activity as a major effort to document community needs.

- Educational efforts on behalf of family groups

  In several communities, all of the agencies at which interviews were conducted were aware of these efforts. This was particularly the case in those Components which invited agencies to participate in the workshops. When agencies provided staff for AC family workshops they were aware of and valued AC efforts in community education.

- Client advocacy

  Many administrators viewed the AC staff as ombudsman or middle men in the relationship between client families and community agencies. In general, the effort to sensitize agencies to the needs of the target population and to make them more responsive was very well received.

All of the agencies at which interviews were conducted were asked whether or not they had the capability of performing the AC functions outlined above. These data are summarized below:

Table V-3. Advocacy functions in other agencies.

	YES	NO
Outreach	8	22
Needs assessment	4	26
Family education	18	12
Client advocacy	6	24

Most health, education, and welfare agencies do not have a capability in the areas covered by the ACs. All of those interviewed stated that they would like their agency to perform these functions because it would help them to deliver their services more efficiently to a larger number of people. Most agencies do not perform these functions because of lack of money and staff. Perhaps the single greatest achievement of the AC projects as a demonstration is the fact that agency administrators value the AC functions and would like to incorporate them into their operations. While not everyone responded with the same enthusiasm as the gentleman who said, "They may be the greatest agency this city has every seen," all of those interviewed concluded that at least outreach, family education, and client advocacy should be a permanent part of their operations.

CHAPTER VI

THE ADVOCACY STAFF

1.0 INTRODUCTION

AC staffing patterns, staff functions, staff training, and staff turnover are described in this chapter. The information was derived from:

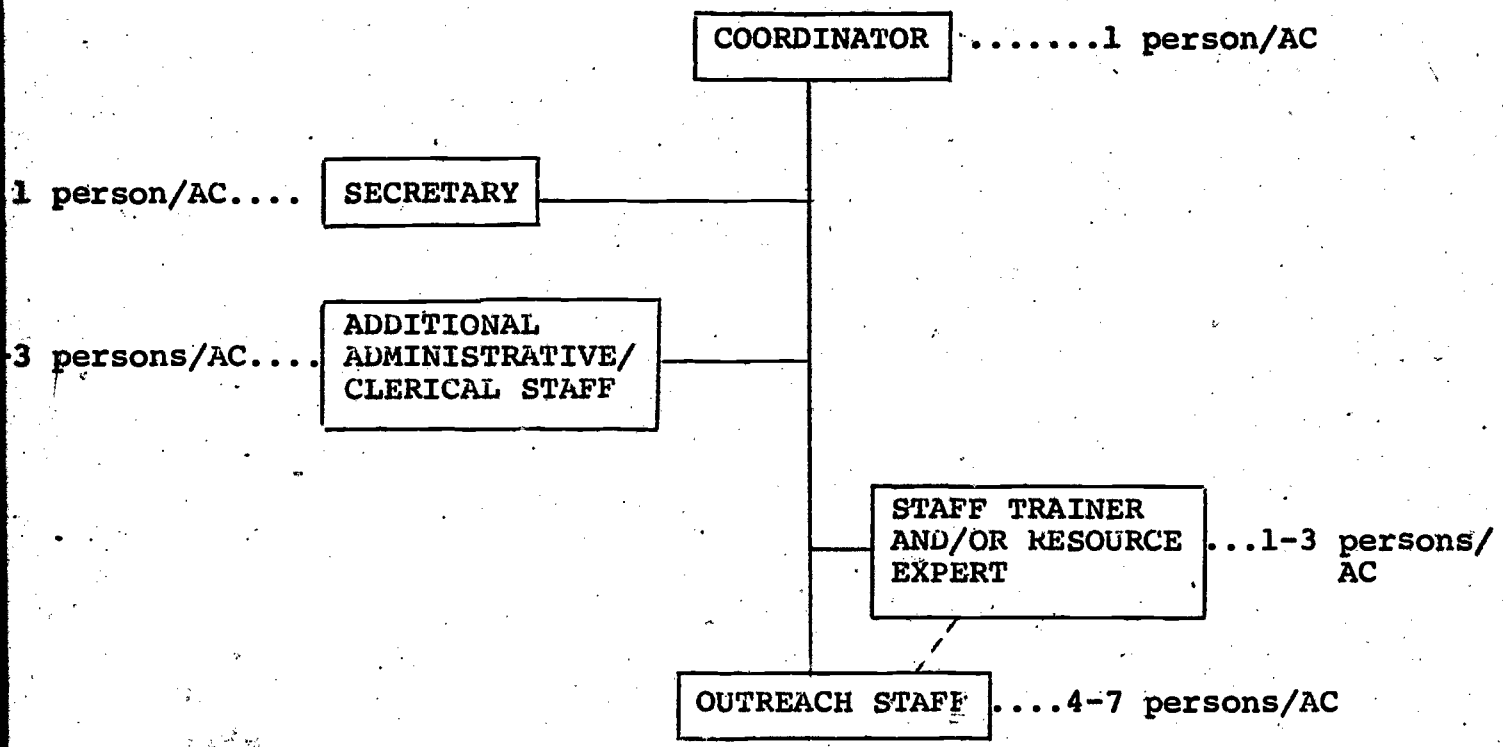
- Interviews with AC staff at the beginning and end of the first year, and at the end of the second year.
- Five site visit interviews with AC Coordinators.
- Monthly Monitoring System reports on staff.
- Monthly Monitoring Time Sheets.

2.0 STAFF ORGANIZATION

As the concept of a Child Advocacy Component was new, so too were the roles and functions of the Child Advocates. Few models existed from which to draw assistance in the design of staffing patterns and staff training programs; those models that did exist had limited applicability. Thus, within the guidelines and framework mandated by the National Office and the provisions imposed by the PCC Parent Policy Councils (PPCs), each of the Components developed staffing patterns in the manner which seemed most suitable to the individual PCC Director, AC Coordinator, and PCC Personnel Committees. For the most part, the guidelines and PCC requirements were broad enough to allow variation, with the exception that most Components interpreted the framework

to include the provision that positions be made available to community persons.

While no Component implemented any standard staffing pattern, the following might be considered a representation of a basic, or modal, pattern:



It should be understood that not every Component had each of the staff lines listed above, while some Components had additional categories. For example, the Leitchfield AC, which did not have a resource expert, had additional staff lines for transportation aides. No other Component had comparable persons on staff. In addition, the Leitchfield and the Huntington ACs also had PCC nurses, nutritionists, and homemakers available to them on a part-time basis. This

use of PCC personnel was common to all projects, particularly during the second project year. In this regard, PCC Directors, various administrative staff members, and some specialized staff (e.g., nurses) were on the AC budgets for from 10 to 50 percent of their time. Those persons who devoted a larger proportion of their time to Component activities were regarded by the AC Coordinators as regular staff. Persons whose AC time was limited (as was usually the case with clerical personnel) often performed tasks that were not so visible that they should be considered "AC staff."

3.0 STAFF ROLES

3.1 Coordinators

The OCD guidelines for the Advocacy Components are quite explicit as to the kinds of qualifications needed by the Coordinator:

> "The Advocate is a key person in the success or failure of the program and must combine many skills in order to carry out the objectives. This person must understand early childhood development; family life in the catchment area; be knowledgeable about community organization and resources; be able to elicit the cooperation of other agencies; and administer a complex program."

However, Coordinators came to the position with varied backgrounds. For example, one Coordinator was a lawyer, one a social worker, one a businessman, and one a former PCC staff member and AC outreach worker. Each brought different experience and expertise to the job; both role and program reflected individual background and experience. Few Coordinators brought previous early childhood experience to the

position. In day-to-day operations, the primary responsibilities of the Coordinator centered around program planning, contacts with resources, staff supervision and administration. Thus, supervisory and administrative experience emerged as more important requirements than did knowledge of child development. When such specific knowledge was needed, resource experts from either the PCC or other community agencies were brought into the program.

The job descriptions and areas of emphasis of the different Coordinators changed as the staffs grew more experienced in particular areas or as the project focus shifted. At the start of AC operations, the Coordinators spent a great deal of their time identifying agencies and establishing linkages. In only two Components was this task divided among the Coordinator and other staff members. However, as outreach staff at all Components began using these linkages for referrals and other family-related purposes, their adeptness at working with administrators and negotiating the service delivery systems increased. Thus, at all but one Component, the second project year saw a greater proportion of outreach staff time being spent on agency activities. This did not so much serve to decrease Coordinator's time in this area as it permitted Coordinators to use this time in a different manner. That is, by sharing the task of resource identification with the outreach staff, the Coordinator was able to devote more time to interagency planning, coordination, and joint AC-agency project development.

In similar manner, the Coordinator role as staff trainer also changed during the course of the program. In the beginning, the Coordinator, and in most cases outside trainers as well, concentrated their training efforts on basic skills such as interviewing, report writing, observation, and referral and follow-up techniques. Sessions were also conducted in certain content areas such as the structure and function of specific agencies and the basics of child development. As with agency contacts, use of these techniques increased competency and shifted the Coordinator's role. As staff became more knowledgeable, the Coordinators began to do more individual supervision than group training. While such training sessions did continue throughout the life of the program, they were more often accompanied by individual meetings and case conferences than had been the case at the start of program. Thus, it seems that the skills required of a Coordinator at start-up are not necessarily synonomous with those most needed once the project is fully installed. In most cases, the growth of the Coordinator's skills were as great, albeit in different areas, as the growth of the paraprofessional staff's skills.

The following is a breakdown of the average proportion of Coordinators' time devoted to specific service categories with an additional line for time off:

	NEED ASSESS-MENT	HOME VISIT/ REFERRALS	WORK WITH GROUPS OF FAMILIES	WORK WITH AGENCIES	STAFF TRAIN-ING	ADMIN-ISTRA-TION	TIME OFF
MEANS	1%	4%	5%	30%	15%	29%	16%
RANGES	0-5%	0-14%	1-19%	10-59%	2-24%	13-50%	9-28%

As was discussed, and as can be seen from the table, the majority (74%) of Coordinators' time was spent in work with agencies, staff training, and administration. Only one Coordinator made a regular practice of conducting needs assessments and home visits. The remaining Coordinators accompanied outreach workers in these activities only in special cases. Similarly, only one Coordinator spent an appreciable amount of time in work with groups of families. While most Coordinators allocated their time to this activity when special events were being planned, the Baltimore Coordinator often spent time speaking with groups of families which met informally in the AC office lounge area.

3.2 Staff Trainers and Resource Experts

Five of the Advocacy Components had between one and three staff who, in addition to the Coordinator, functioned as staff trainers and resource experts. At the Boston and Cleveland Components, there were specialists who related to either health, housing, education, or welfare. In Boston,

the original staffing pattern called for the hiring of team leaders with previous experience in health, education, or welfare, whereas in Cleveland this pattern evolved as a result of increased outreach worker expertise in a particular field. In addition, the Cleveland AC originally had a full-time trainer on staff. When the first Coordinator was replaced by a person with extensive experience in training and supervision, the staff development coordinator took on the tasks of data coordination. The Huntington Component used field placed social work students as staff trainers/ resource experts, whereas the Jacksonville AC utilized a lead child advocate in this position. The Baltimore project had a somewhat different staffing arrangement. The staff included a public information specialist who was responsible for agency coordination around special workshops, an assistant coordinator who chaired Teenage Mothers' Group meetings and did some staff supervision, and a community organizer who was hired during the second project year to share the Coordinator's agency contact responsibilities. The Leitchfield Advocacy Component was the only project which did not have a middle-level person on staff.

For the most part, Coordinators were satisfied with this type of staff pattern. However, while most would not want to eliminate this middle position, several Coordinators commented that, given the opportunity to re-staff a similar project, they would look for persons with more administrative

experience than was represented by several of the staff trainer/resource experts. Experience with the project has suggested that, in actual practice, much of the day-to-day supervisory responsibility falls to the resource specialist. Thus, in cases where this individual had no supervisory experience, the results tended to be less than optimal.

The following is a breakdown of middle level personnel's time across the service categories and time off:

	NEED ASSESS-MENT	HOME VISIT/ REFERRALS	WORK WITH GROUPS OF FAMILIES	WORK WITH AGENCIES	STAFF TRAIN-ING	ADMIN-ISTRA-TION	TIME OFF
MEANS	3%	3%	9%	12%	25%	32%	16%
RANGES	0-8%	1-6%	0-18%	3-16%	11-44%	12-50%	9-23%

The allocation of resource expert and staff trainer time is similar to that of Coordinators. That is, the majority (69%) of these persons' time was spent in activities related to agency contacts, staff training, and administration.

3.3 Outreach Workers

These persons were the target families' primary contact with the AC. Regardless of their other responsibilities, the outreach workers conducted needs assessments, made home

visits, maintained contact with families, and effected referrals. At all but one Component, outreach staff also shared the responsibilities of identifying resources and services and in some cases attending interagency meetings or serving on agency boards. A breakdown of average time allocations of outreach staff follows:

	NEED ASSESS-MENT	HOME VISIT/ REFERRALS	WORK WITH GROUPS OF FAMILIES	WORK WITH AGENCIES	STAFF TRAIN-ING	ADMIN-ISTRA-TION	TIME OFF
MEANS	13%	24%	4%	7%	14%	18%	20%
RANGES	10-22%	18-33%	1-10%	2-17%	8-20%	8-35%	14-24%

A considerable portion of outreach staff time was devoted to activities with families: needs assessments, home visits, and referrals. While the proportion of time spent working with agencies is low, on the average, this does represent an increase over time spent during the start-up year. It should be noted that the 14% of time allocated to staff training represents attendance at training sessions, whereas the allocations for Coordinators and middle level personnel represent planning and conduct of sessions.

For the most part, outreach workers were indigenous to the community, and thus familiar with family life in the catchment area. This fact has been cited by Coordinators

as having both positive and negative aspects: positive in that it aided in the establishment of worker-family report, but negative in that it was often difficult for workers to separate themselves from their client families and achieve a certain degree of "professional detachment."

4.0 IDEAL STAFFING ARRANGEMENTS

With few exceptions, the Coordinators stated that the ideal Advocacy Component staff would be slightly larger (one AC suggested a decrease in staff positions), somewhat more diversified, and more experienced and/or educated than had been the original staffs (only one Component indicated a preference for paraprofessional rather than professional staff). In this ideal arrangement, staff functions would not change as much as would the qualifications of the persons performing these functions. The Coordinator's position would be almost the same as was originally indicated. Requirements for the position would include an academic degree or comparable experience/training in the social sciences. Additional qualifications include community organization skills and the ability to deal effectively with persons from both the community and agencies. Few changes in the Coordinator's role were indicated. However, those persons who opted for a more professional staff commented that the support which would be provided by such a staff would allow the Coordinator to concentrate more time and effort in the area of agency negotiations and class advocacy type actions.

The Coordinators of the two rural projects indicated that they would want some combination of staff lines to include a nutritionist, a nurse, and/or a homemaker. These positions had, in fact, been provided to the Components through their PCCs. These staff positions were not mentioned in urban areas where the community agencies are large enough and diversified enough to offer such resources to the projects on an as-needed basis. In addition, the Huntington Coordinator indicated a need for transportation aides, positions that were available to the other rural AC. The Leitchfield Coordinator included both a homemaker and transportation aides in her ideal plan, but added that if feasible she would want these persons to be made available to the project through another agency in the community. Whereas the rural Components indicated a desire for health professionals, the urban Components responded with a greater variety of middle positions. One Component wanted a staff psychologist, one wanted a team of community organizers (one highly trained person and one with less experience), while another was interested in obtaining the services of a caseworker. In all instances, the key quality desired was strong background and experience. Other additional positions in these ideal patterns included assistant coordinators (to do paperwork), program specialists (to coordinate special, ongoing group activities), data coordinators, and, in one Component, a staff member with a legal background whose primary function would be to meet with persons on the state level in order to lobby and advocate

for needs across the entire state.

While in many instances comments indicated a desire for more top and middle level personnel, every Coordinator was in agreement about the value of an outreach staff. It was well understood that these workers form the backbone of the project, and no one suggested a redefinition of their roles in the organization. The comments most frequently made related to a desire for at least some portion of the outreach staff to come to the job with more training or background than had been the case. These comments basically stemmed from a feeling that staff training had consumed a larger share of time and effort than was originally anticipated, and that a staff with more previous experience would require less initial training before the "business of Advocacy" could get underway. The suggestion made by one urban Coordinator was that the Component should have a team of six outreach workers: three persons with a minimum of two years of college training and three community assistants who would be required to attend school while employed by the AC. This Coordinator further suggested that once the assistants received their GEDs, they would be replaced so that a greater number of community persons could receive training. In discussing the types of skills they would like to see in outreach workers, Coordinators mentioned knowledge of social behavior, ability to write reports and letters, discipline to work, and a capacity for verbal communication both with

families and agency administrative personnel. There were some differences of opinion as to whether the outreach staff should come from the AC's catchment area or not. One Coordinator said that she would not recommend hiring all outreach workers from among PCC mothers or catchment area residents, as they have been in a social relationship with those families with whom the AC works. Thus, the transition from friend to service deliverer is too great. However, another Coordinator indicated that she would only want catchment area residents as outreach staff because of their interpersonal relationship with the families and because "they know what it is to be down -- they've been there."

Overall, it appears that the ideal staffing pattern would not differ significantly from the actual pattern which emerged. The major difference would be the degree of training and/or experience each person would bring to the position.

5.0 STAFF TURNOVER

Since the inception of the program, there has been a 75% turnover rate among outreach workers: 50% during the first project year and slightly over 25% through June of the second year. This turnover rate is attributed to job dissatisfaction, job insecurity, promotion to better positions, and in some cases pregnancy. In addition, seven persons in the resource expert category and ten clerical staff members have left. One rural program with a nurse and a nutritionist lost both of these persons during the first year, hired another

nutritionist and lost her as well. The other rural program with a nutritionist also experienced turnover in this position. As of June, 1974, only two of the original six Coordinators remained, those in Boston and Huntington; the Baltimore Coordinator left his position in May and was not replaced due to the impending termination of the project; the Cleveland Component was headed by its second Coordinator; Jacksonville's fourth Coordinator remained in her position; and the second Leitchfield Coordinator was preparing to leave to take on a more permanent job.

The high rate of turnover is not inconsistent with the experience of other similar community programs. The Kirschner Study[1] on the start-up year of the PCCs reports a 27% turnover rate, with turnover rates of 70-100% in a number of programs. While the high AC turnover rate is therefore not unusual, it did present difficulties to the programs. As would be expected, each new Coordinator came to the position with his/her own experience and viewpoint as to how the program should be structured and what the emphasis should be. Thus, a change in Coordinators was often accompanied by a change in program emphasis. At times the shift was beneficial, while at others the process of change and the lack of continuity temporarily decreased program effectiveness. Among outreach staff, turnover often produced difficulties in the area of staff training.

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[1] Kirschner Associates, Inc., 1970, A National Survey of the Parent-Child Center Program; Office of Child Development Contract No. B89-4557.

The new outreach worker on staff did not have the benefit of the initial, intensive training efforts and frequently had to learn on the job. While in many cases the skills were in fact learned, the transition period was one of diminished productivity.

6.0 STAFF TRAINING

Staff training received considerable emphasis at most Components. While the topic areas varied as program stress and workers' needs shifted, training of staff was ongoing throughout the life of the project. The second year CCR Monthly Monitoring System collected data on:

- the total number of staff training hours/month/Component
- the number of hours/month/type of training session
- the number of hours/month/topic area presented

6.1 Types of staff training

Within the areas of techniques, issues, case-related training, and individual and/or AC operations-related staff meetings, the topics covered by each Component varied. At some Components, the techniques used in home visiting, interviewing, report writing, and agency referral and follow-up were covered in early group training sessions and then were discussed, on an as-needed basis, during individual supervisory meetings. At other Components, training in these technique areas

continued throughout the life of the program. Whether conducted on a group or an individual basis, continuous training in technique was mandated by the Coordinators for two reasons: (1) staff turnover was such that the workers who had been part of the initial training programs were not always those who were using these skills at any point during operations; and (2) as the Components moved into new areas and as staffs gained sophistication and competency, it became necessary to elaborate on the original basic skills that had been taught. Training sessions on technique during the second year included such topics as speech writing, working within the schools, use of audio visual equipment, social work and case counseling skills, mental health and child development, and involving parents in program.

"Issues" was the term used to describe topics of national, state, and local interest as well as areas concerning particular community agency practices, plans, or changes. In this area, topics discussed in staff training sessions included: the abused child, the energy crisis, pending legislation, alcoholism, food stamp calculations, social service changes, and career opportunities. In most cases, "issue training" was conducted by community resource persons who were specialists in their respective fields. This was perhaps the area in which outside experts were used most frequently.

Case-related training took two forms: case conferences and individual supervisory meetings. When case conferences were

held, the category of training often overlapped with technique training. That is, a case would be discussed and all staff members would have the opportunity to hear what steps had been taken in the case and to suggest further actions that would be appropriate. Individual supervision around cases also involved suggestions in terms of possible actions.

In many cases, staff meetings concerned with AC operations developed from discussions of methods for completing the CCR reporting forms. Some of these sessions were used to help clarify reporting procedures while others were opportunities for group collection and review of reporting information. The other class of materials covered under this topic included AC personnel procedures, AC/PCC relationships and individual personnel requirements or difficulties.

In viewing the data presented below, it should be understood that the total number of training hours does not, in all cases, represent training received by all Component staff members. That is, included in these figures are school classes and agency workshops that, in some instances, were attended by only a few staff members.

AVERAGE # TRAINING HOURS/MONTH/COMPONENT	40
RANGE (ONE MONTH AT ONE COMPONENT)	2-183
TYPES OF TRAINING SESSIONS (BASE = 40 HOURS/MONTH)	
AVERAGE # OF LECTURE HOURS/MONTH/COMPONENT	6
AVERAGE # OF WORKSHOP HOURS/MONTH/COMPONENT	8
AVERAGE # OF COURSE WORK HOURS/MONTH/COMPONENT	3

AVERAGE # OF INDIVIDUAL SUPERVISION HOURS/MONTH/ COMPONENT	10
AVERAGE # OF GROUP SUPERVISION HOURS/MONTH/COMPONENT	13
CONTENT OF SESSIONS (BASE = 40 HOURS/MONTH)	
TECHNIQUE TRAINING - AVERAGE # HOURS/MONTH/COMPONENT	11
TRAINING ON ISSUES - AVERAGE # HOURS/MONTH/COMPONENT	12
CASE-RELATED TRAINING - AVERAGE # HOURS/MONTH/COMPONENT	4
ADMINISTRATIVE STAFF MEETINGS - AVERAGE # HOURS/MONTH/ COMPONENT	13

It is likely that the number of hours spent conferencing around case-related areas is underrepresented by these figures. The types of training most often given for case-related issues are provided in individual supervision or may include training in particular techniques, e.g., interviewing, follow-up, etc. Thus, these topic areas outlined may be overlapping.

7.0 ADVOCACY AS A NEW CAREER

The OCD guidelines state:

> "Training efforts should be directed not only at program needs but should include a broader spectrum such as identifying child advocacy as a new career and involving educational institutions in the development and implementation of a curriculum for advocates. Another focus might be the development of jobs in the public and private sectors."

During the start-up year, the training of AC staff consumed the time and effort which might otherwise have been directed at a broader population. However, the Coordinator of one Component did undertake to teach a college level course on advocacy, and to encourage the college to initiate an advocacy training program. While the one semester course

was completed, it did not become a regular part of the curriculum nor was a training program developed. Perhaps the only effort during the start-up year that produced tangible results in terms of the new career objective was that of the Boston AC's involvement in the Children's Hospital Patient Advocacy program.

While most Coordinators could point to an agency within their catchment areas that could benefit from the inclusion of an Advocacy Component, the experience during the start-up year made AC staff aware of the difficulties involved in agency expansion and change, and expectations in this area declined. Thus, rather than attempting to have agencies develop their own Advocacy Components, arrangements were made whereby AC staff would perform Advocacy functions on behalf of these agencies. It was not until notice of project termination was received that Coordinators began an extensive effort to find agencies to take on the Advocacy functions. The problem was not that agencies did not want advocates, but rather that they did not have available funds to undertake the effort. In some cases, PCC and Head Start programs wanted to incorporate the Advocacy Components into their structure, in other cases the local school personnel felt that they could benefit from a team of advocates, but in almost all cases the resources needed to take on the Advocacy functions were not available. At the time of this writing, only one Component, Cleveland, was assured of its continuation after the termination of

federal funding. Thus, although efforts were in fact made, the Advocacy experience did not result in the development of a curriculum to create "career advocates," nor in the widespread adoption by community agencies of Advocacy functions.

CHAPTER VII

COMPONENT COST DATA

1.0 INTRODUCTION

The second year's cost monitoring relied upon data submitted to CCR monthly as follows:

- Daily staff time logs, maintained at each AC.
- Wage/salary schedules for each worker, so that the costs associated with each job level could be computed.
- Monthly component budgets, prepared by the Coordinators, reflecting expenses charged to each of six functional categories: needs assessments, home visits/referrals, family group meetings, agency contacts, staff training, and administration.

The data presented in this chapter are compiled from the above sources, covering the period November, 1973, through June, 1974, inclusive.

Initially, it had been planned to provide estimates of the value of captured resources made available through the efforts of the ACs. This turned out to be unfeasible because in many instances resources were unable to attach a dollar value to their services and in other instances the range in terms of costs for a particular service was so great as to make it impossible to provide meaningful and reliable data on the value of captured services. For example, in attempt-

ing to establish the value of immunizations, CCR was advised that the cost of individual immunizations ranged from $1.00 to $12.00; similarly, the cost of lead poisoning tests ranged from $1.00 in one community to $30.00 in another community.

2.0 COMPONENT EXPENDITURES

Cost data were collected with respect to standard budget categories, including: personnel, equipment, supplies, staff transportation, client transportation, postage, telephone, rent, contingency funds, consultants, temporary employees, other. For the purposes of presentation, only the personnel category is broken out; all other budget categories are combined as "other than personnel" (OTP) expenditures.

The average monthly cost per Component was $8,139. Projected to an annual basis, the rate would be $92,662. When separated into personnel, OTP, and total costs, the data are as follows:

	Average/month	Median/month
Personnel	$5,979.	$6,227.
OTP	2,160.	929.
Total	8,139.	7,493

As with all of the cost data, and as will be discussed later in this chapter, there was considerable range of costs among the various ACs -- the "highest cost" AC spent almost twice (1.9 times) as much as the "lowest cost" Component. Given the potential for skew in such data (as later discussion will show there was strong positive skew), the median is a better measure of central tendency than is the mean; thus, it might be more appropriate to project a monthly cost of $7,493, than to base estimates on a mean cost of slightly over $8,100 for the same period. While the monthly difference appears small, on an aggregate basis over a year's period among six centers, the difference in projection would amount to $43,704, or 7% of the entire AC budget.

In any event, slightly less than three-quarters of all AC expenditures were for personnel. As might be expected in a program which does not provide direct services and thus requires little by way of capital resources, personnel expenditures far outweigh other classes of expenditure, by a ratio of four to one. As will be seen later, the relationship between personnel costs and OTP costs varies markedly according to functional category addressed, and according to rates varied widely from project to project, in general being considerably greater in urban areas. Illustrative of this range are the annual salaries in each of three staff levels, as presented below:

Coordinator	-	$6,302 - $13,995
Resource Expert	-	6,864 - 10,920
Outreach Worker	-	3,993 - 6,375

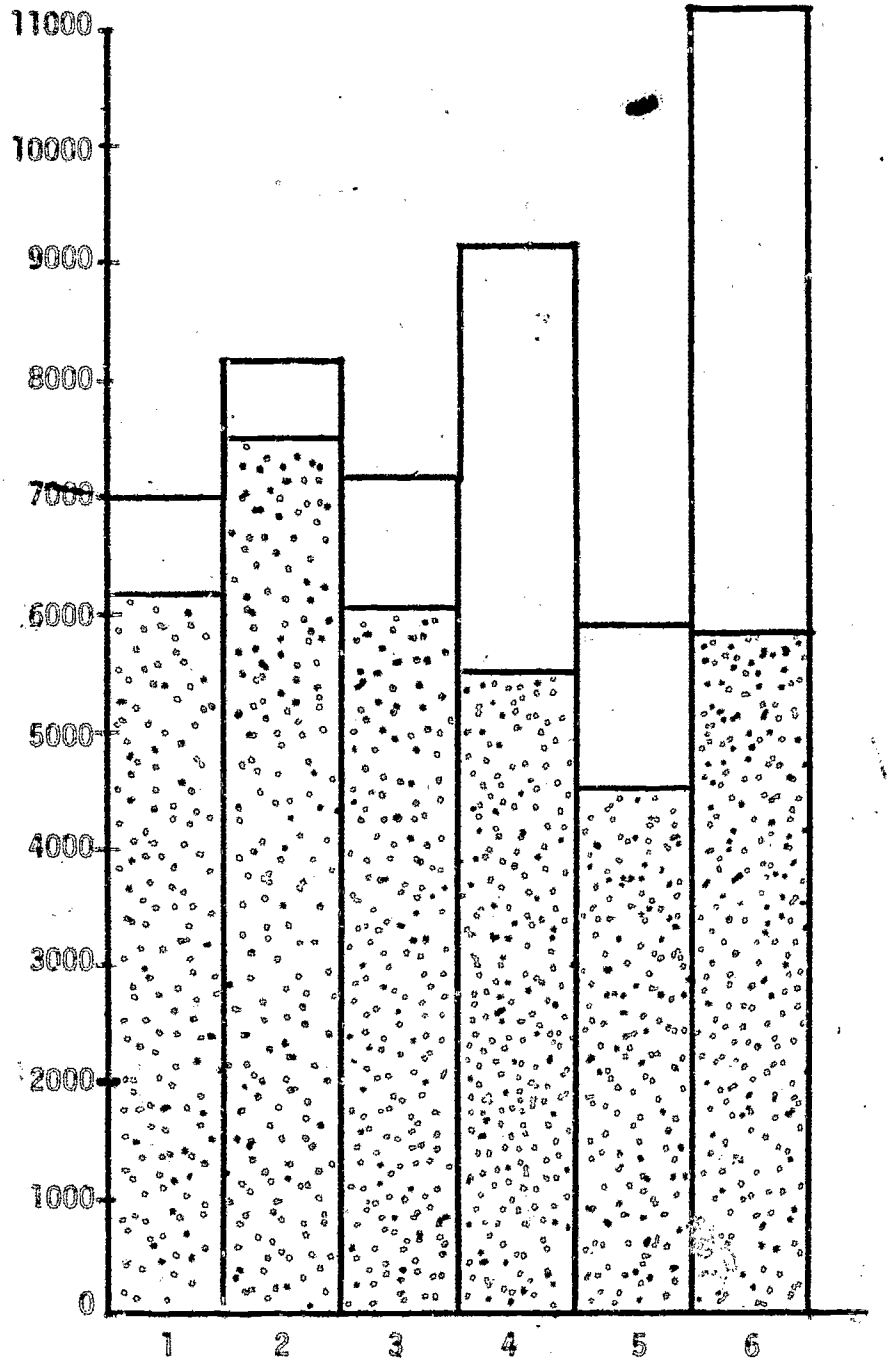
2.1 Costs/individual Component

Average monthly costs for each of the ACs are presented below.

AC	MONTHLY AVERAGE	12-MOS. PROJ.
1	$ 6,997	$ 83,964
2	8,268	99,216
3	7,332	87,984
4	9,247	110,964
5	5,877	70,524
6	11,112	133,344

As a means to emphasizing the differences among the ACs, in terms of total cost experience, individual AC costs are represented in Table 1, below.

Table 1. Total costs/monthly means.



Other than personnel

Personnel

As will be noted from examination of the preceding histogram, the range in personnel expenditures is far less than the range in OTP expenditures. For example, the ratio of greatest to smallest personnel expenditures is 1.6 to 1; that of greatest to smallest OTP 8.5 to 1. Stated another way, OTP expenditures were particularly salient in creating inter-component cost differentials. Further underlining the relative importance of OTP expenditures, there is considerable similarity in total costs among four of the Components; among these Components, OTP expenditures account for less than 20% of total costs. Among the two Components which were distinctly different in terms of total cost, OTP costs represented more than one-third of all expenses. This marked proportional increase in OTP expenses occurred at the two rural Components, where transportation costs, and in one case direct payment to the health department for medical and dental work, account for the increase.

2.2 Costs related to functional areas

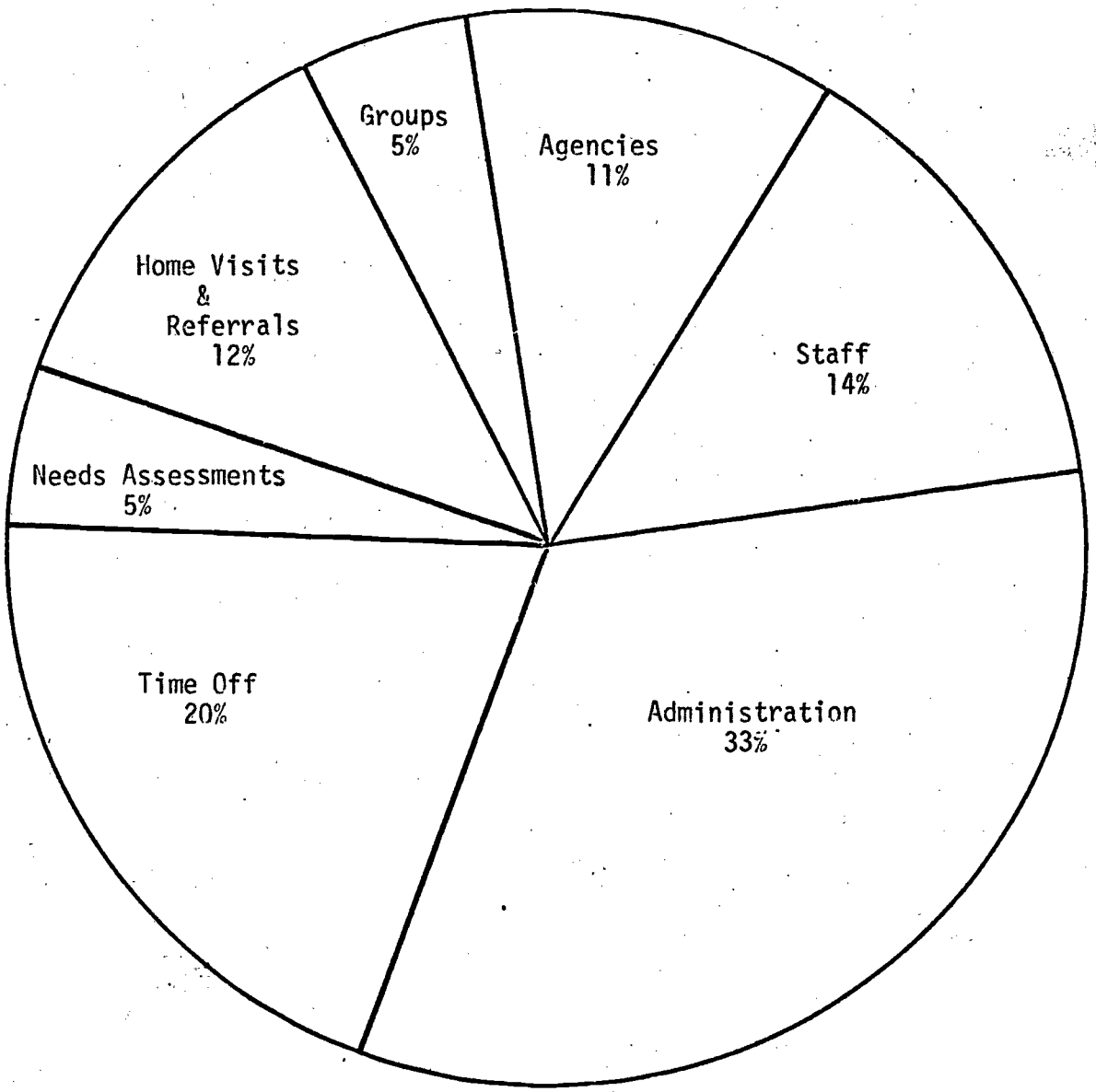
Costs were assigned to the different functional categories, as a means to "pricing out" the various elements which combined to make up the Advocacy programs. Data reflecting cost experience with respect to each of the functional areas are presented below, in Table 2.

Table 2.

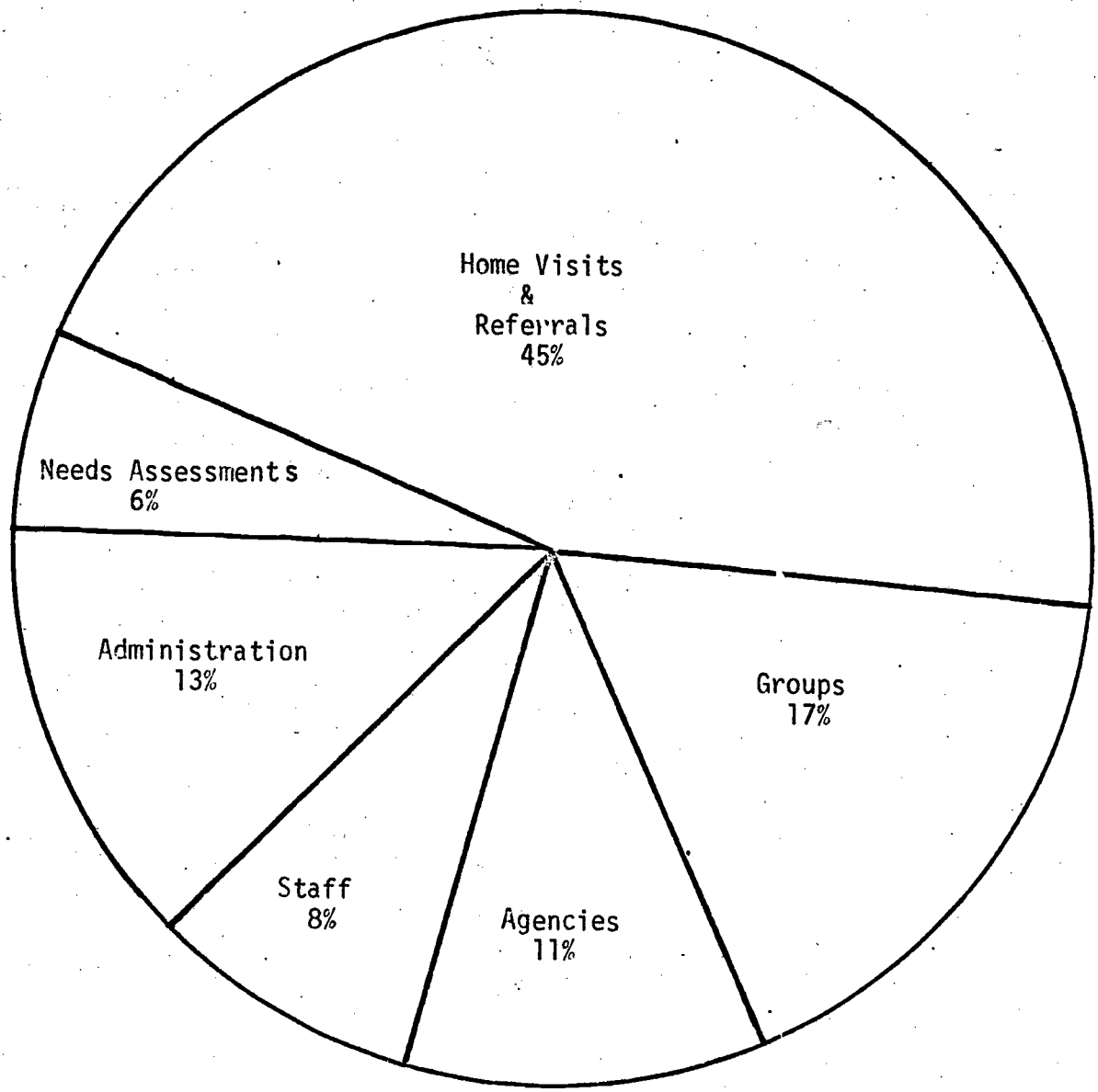
	MDN.	MEAN	S.D.	SKEW	MIN.	RANGE
NEEDS ASSESSMENTS						
Personnel	224.5	288	200	.3104	0	750
OTP	43	131	181	2.2668	0	775
Total	407.5	419	257	.2860	18	953
HOME VISITS/ REFERRALS						
Personnel	615	699	345	.5401	65	1,482
OTP	247.5	970	1,786	3.0691	8	8,945
Total	892	1,669	1,935	2.6857	194	9,566
GROUPS						
Personnel	256.5	302	238	.5996	12	796
OTP	145.5	369	658	2.7268	0	2,846
Total	405	671	690	2.1097	129	2,997
AGENCIES						
Personnel	563.5	631	355	.5545	95	1,500
OTP	95.5	240	366	2.3071	0	1,473
Total	747	871	489	.7185	134	1,924
STAFF						
Personnel	812	878	365	1.3742	400	1,739
OTP	76	165	259	3.1802	0	1,341
Total	929	1,042	437	.9434	477	1,685
ADMINISTRATION						
Personnel	1,799.5	1,966	718	.6036	847	2,978
OTP	169	286	252	.7268	15	796
Total	2,027.5	2,252	712	.6978	1,172	2,945
TIME OFF						
Personnel	851	1,214	725	.9794	408	2,575
OTP	0	0	0	0	0	0
Total	851	1,214	725	.9794	408	2,575

Because of the extreme ranges encountered, e.g., $8.00 to $8,945. in one functional OTP category, accompanied by relatively great skew components, the median is a more reliable measure of central tendence than is the mean. It must be pointed out that this extreme difference in costs is due to the fact that at most Components, OTP costs for home visits and referrals involved only transportation costs, whereas in the Leitchfield Component, direct payments for family health care visits raise the OTP costs.

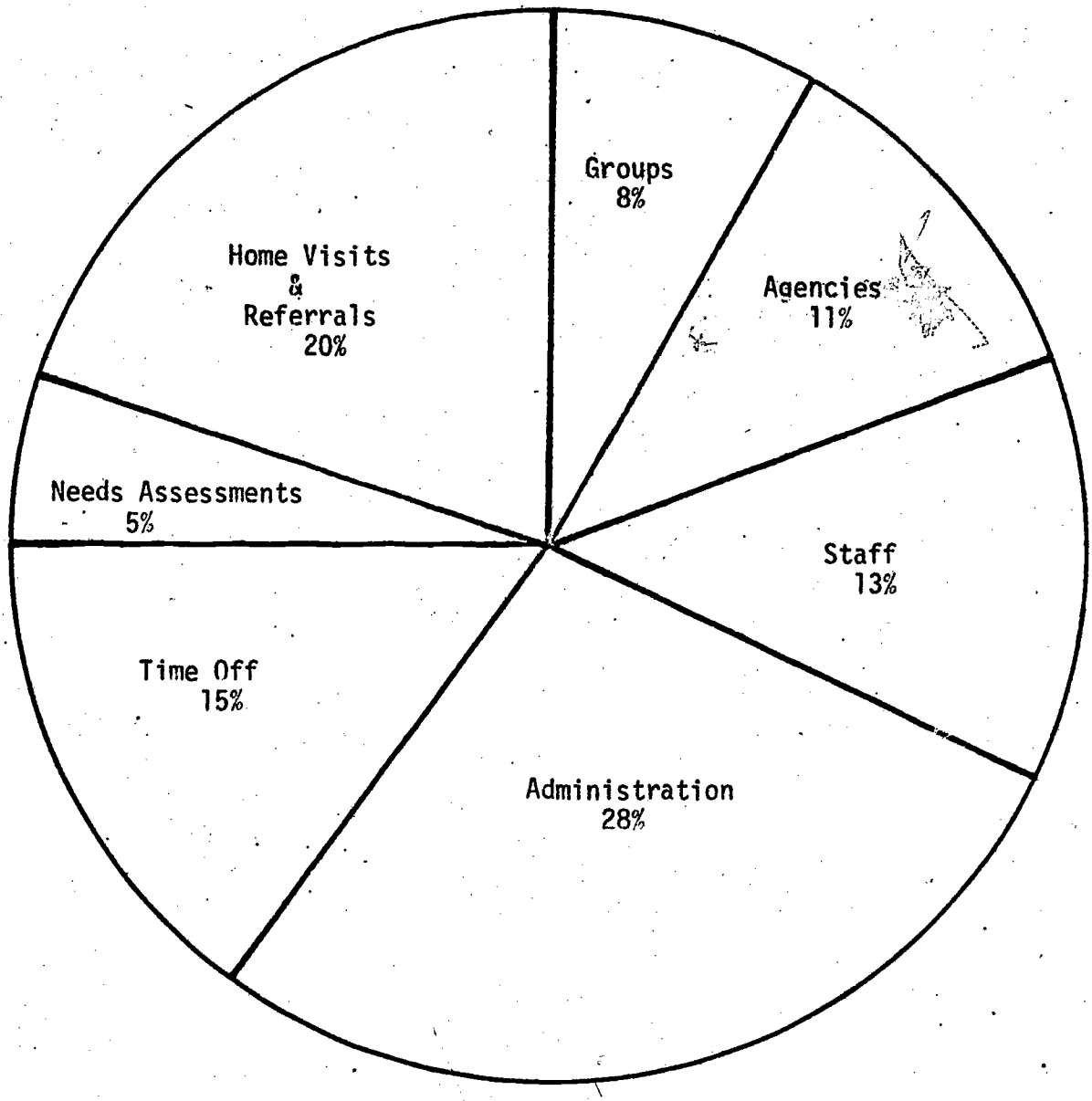
As will be noted from an examination of the preceding data, and of the pie charts which follow, "Administration" and "Time Off" represent the largest cost outlays, in relative terms.



PROPORTION OF PERSONNEL COSTS ALLOCATED TO EACH FUNCTION



PROPORTION OF OTHER THAN PERSONNEL COSTS ALLOCATED TO EACH FUNCTION



PROPORTION OF TOTAL COSTS ALLOCATED TO EACH FUNCTION

The relative magnitude of the administration function, which represents the single largest functional category in personnel costs, can be understood best in the context of those tasks which were included: all clerical typing, filing, bookkeeping; most of the data coordinator's tasks, and the reporting, correspondance, proposal preparation, and documentation tasks of the Coordinators. In addition, at Components where the program paid some portion of the PCC Directors' salaries, the expenditures were charged to "administration." Thus, for example, the two staff members who were universally the highest salaried, the PCC Director and the AC Coordinator, had a great many administrative tasks and therefore most of their time was charged to administration. Thus, the relative cost allocation does not necessarily reflect the relative person-hours allocation. OTP costs allocated to administration are proportionately smaller, which is a function of the fact that the Components bought relatively little capital equipment, e.g., typewriters, which could be charged to administrative costs.

It is noteworthy that 20% of all personnel expenditures were on behalf of "time off." After subtracting weekends, there are 261 days in the year. The 20% "time off" statistic indicated that, on the average, each individual was absent from work 51 days per year. Assuming a relatively liberal policy of 15 vacation days, 15 sick days, and 12 national and local holidays, this would still leave 9 days -- or

approximately two work-weeks -- unaccounted for. In fact, "each" worker was not absent for such a major portion of time; the rates varied, most often according to staff level. For example, outreach workers were absent from their jobs (for all reasons, including vacation, etc.) one week in every five. Most outreach workers were women hired from the community; for many this was a first job, usually undertaken in addition to being responsible for raising a family. At times of family crisis, major or minor, the mother was needed in the home to take care of the children.

However, no matter the reason, two functional elements -- administration and time off -- together account for more than 50% of all Advocacy personnel expenditures. In attempting to assess the costs of these model projects, or to project costs to similar programs, the potential cost significance of these two functional categories should be examined carefully, particularly in the face of specific program expectations.

Home visits and referrals were second in order of total cost magnitude, but fourth in terms of personnel costs. On the one hand, because most of the community workers responsible for the activities were the lowest paid in the Components, the reliance upon cost-ordering results in an underestimate. On the other hand, the fact that the order of cost magnitude is as great as is shown in Table 2 is due in large part to the relatively great OTP expenses involved

in these functions. Particularly in rural areas, considerable monies were required for transportation, of both staff and clients, thus raising the cost of the function as a whole. In addition, as already discussed, one rural Component made direct payments to the health department for medical check-ups. As an examination of the histograms in the following pages will indicate, OTP costs in one rural center, in particular, were sufficient to severely bias the mean value associated with this function.

The comments pertaining to the relatively low salaries received by outreach workers are to be borne in mind when considering the fact that costs associated with "needs assessments" were the lowest of any functional category -- despite the emphasis placed upon this function at the national level. Again, the cost data do not reflect priorities attached to various functional activities, but rather the cost data reflect the salary level of the staff primarily responsible for performing the particular function.

Staff training, which has relatively small OTP costs associated with it, received 14% of personnel monies. It is to be expected that in a program which is staffed by paraprofessionals a major portion of staff time will be devoted to training.

Thirty-three percent of the personnel costs were allocated to program functions: needs assessments, home visits

and referrals, family group meetings, and agency collaboration and referrals. As already discussed, this is not a function of person-hours devoted to these areas, but the fact that most of these activities were performed by relatively lower salaried staff.

Following are presented histograms of different Components' cost experience with respect to each of the functional categories.

Table 3. Time off.

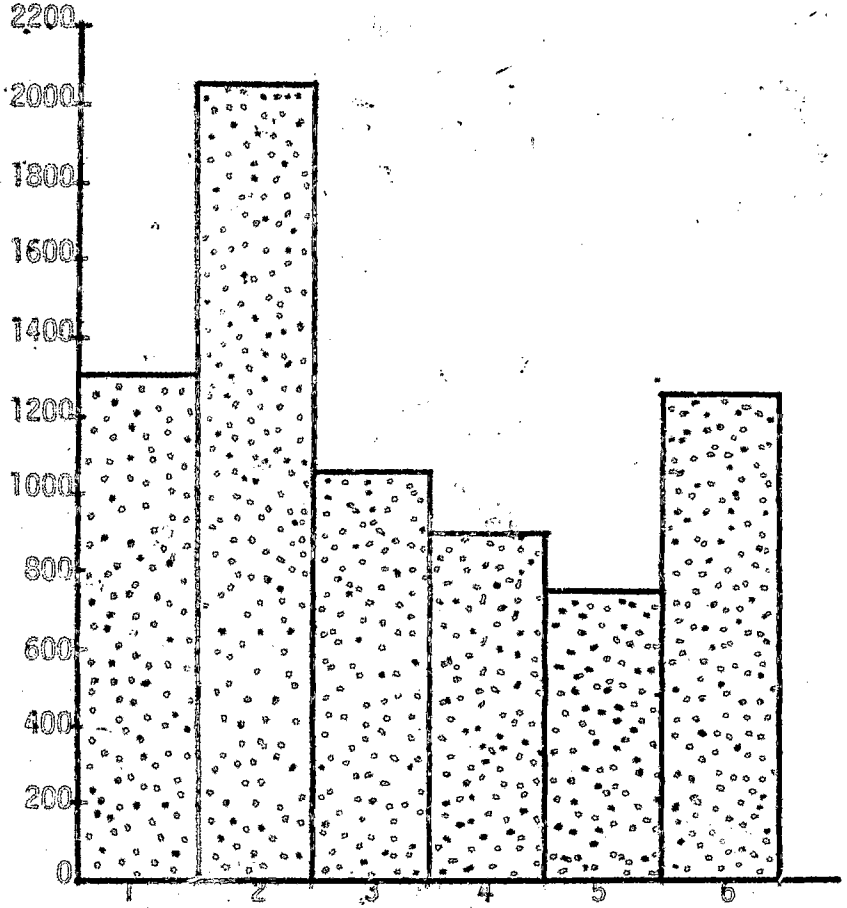


Table 4. Agencies.

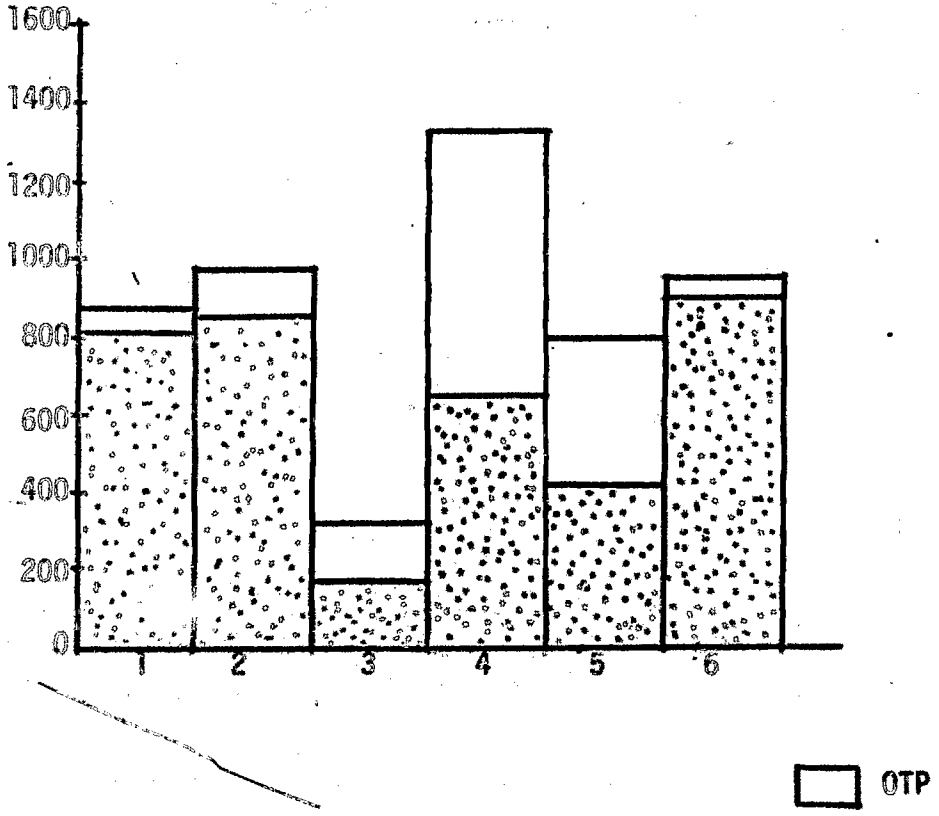


Table 5. Staff.

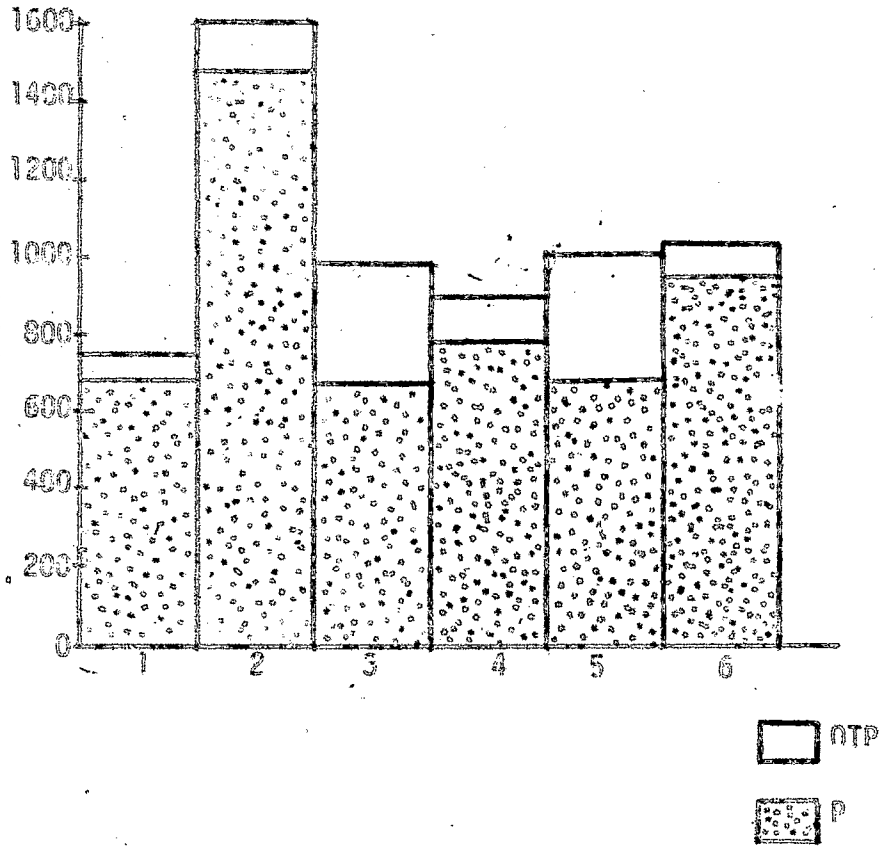


Table 6. Administration.

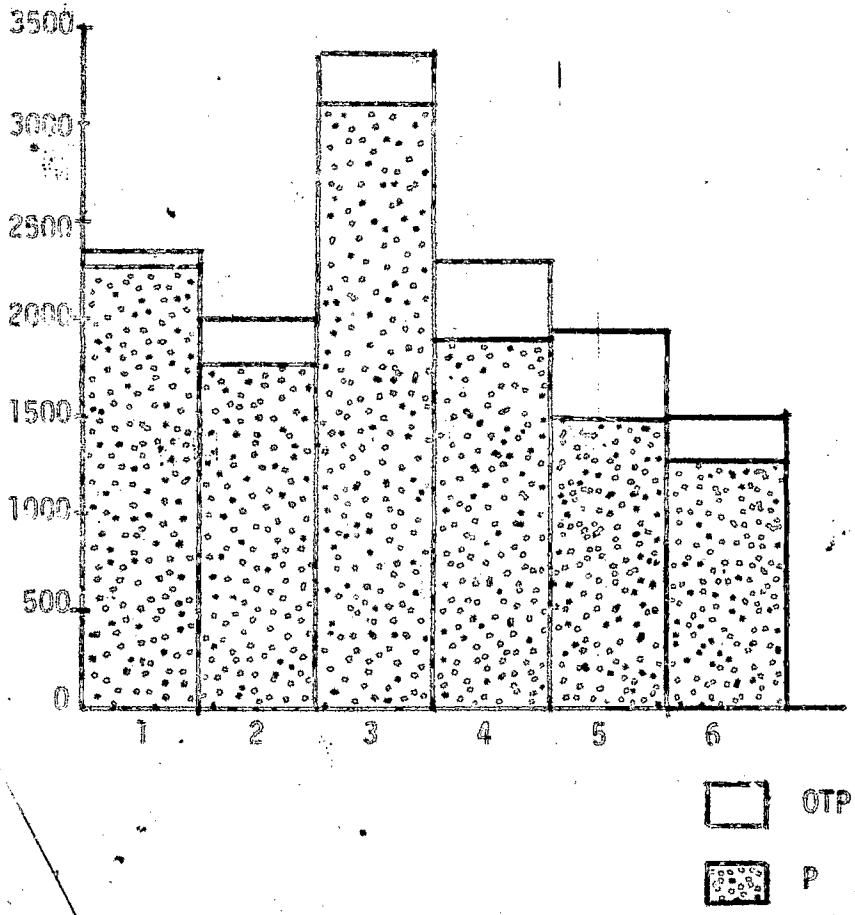


Table 7. Needs assessments.

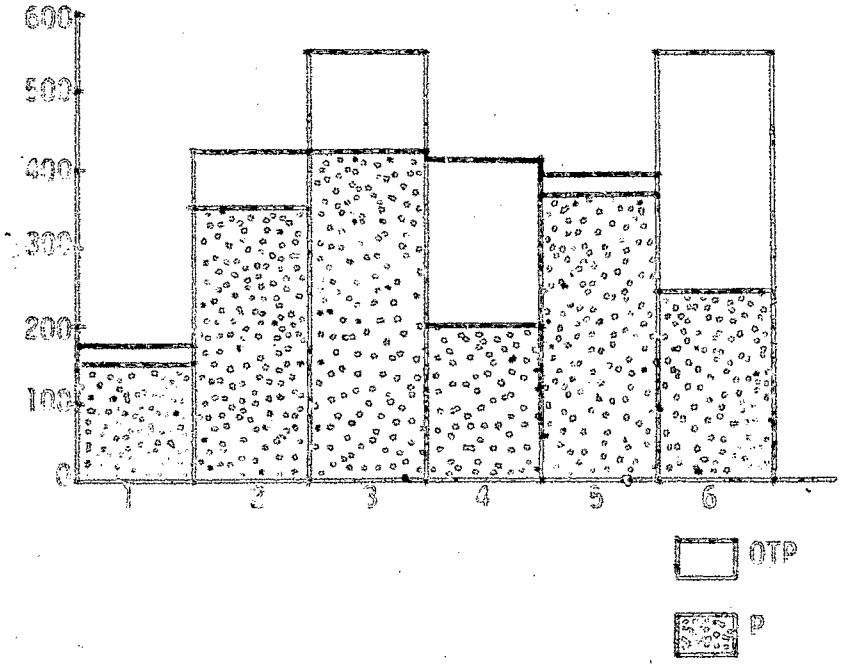


Table 8. Home visits and referrals.

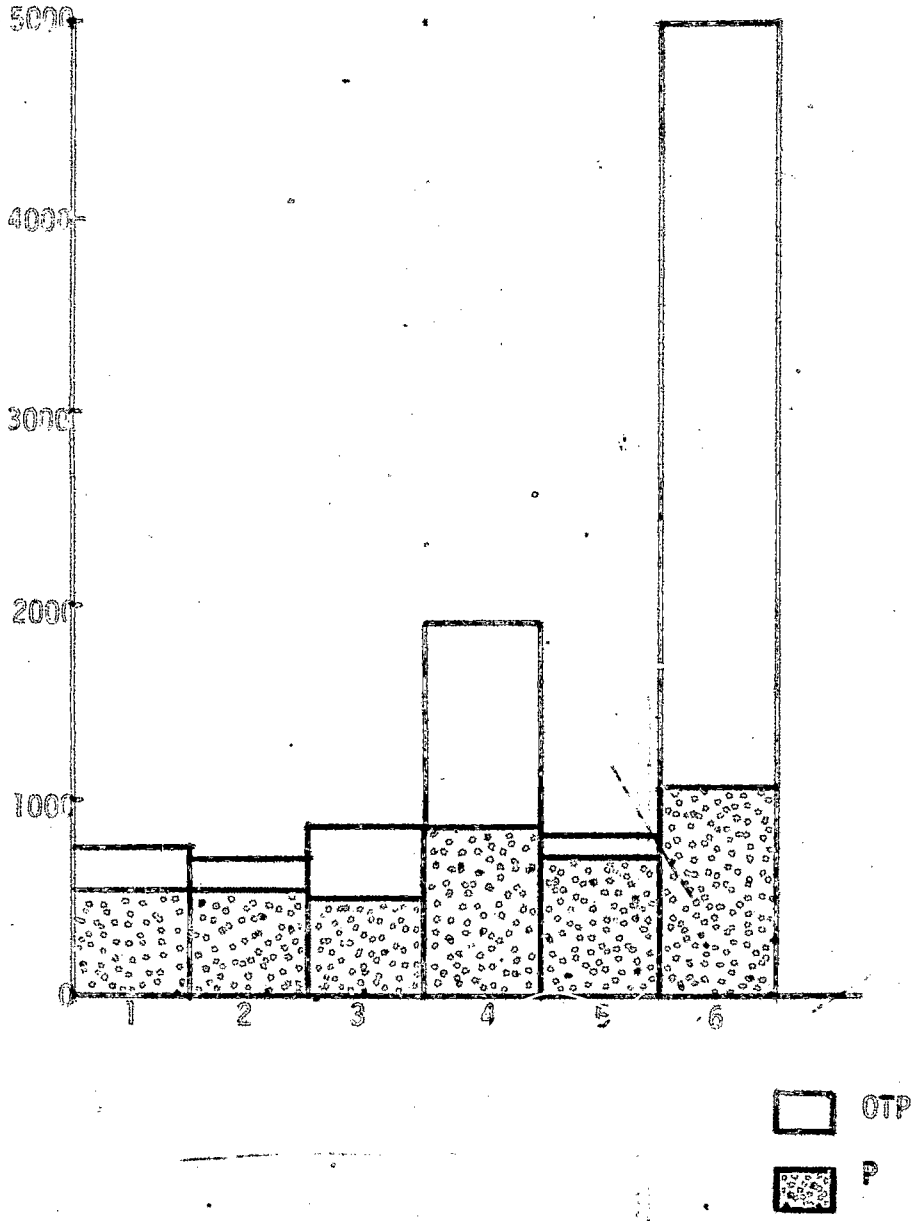


Table 9. Groups.

As the preceding histograms indicate, and as was suggested earlier by the relatively great magnitude of the various standard deviations, there is wide variation among ACs, with respect to each of the functional areas. As indicated by the presence of standard deviations that often exceeded the mean values, the variation among Components in terms of OTP costs, in particular, is marked. Also striking is the difference in terms of variation between home visits/referrals, on the one hand, and administration on the other. Apparently, the latter category is fairly consistent, across different Components, in different locales, facing different problems and serving different constituencies. It is also apparent that the rural Components are similar, in terms of two functional areas in particular: intake assessments and work with family groups.

Two special attempts were made to reduce variation in cost data among Components -- or at least to control for any underlying systematic variation in the data. The first of these consisted of a two-way factorial analysis of variance (ANOVA), in which the structure was as follows:

		Variable					
		1	2	3	4	.....	k
Functional Categories	1	·	·	·	·	·	
	2	·	·	·	·	·	
	3	·	·	·	·	·	
	4	·	·	·	·	·	
	.						
	.						
	.						
	5						

etc.

(Cell scores consist of each individual Component monthly total, for each of the functional categories.)

Results of this analysis were as follows:

Source	df	SS	MS	F	
Months	5	1,538,733	307,756	0.3866	NS
Func. Cat.	6	79,619,811	13,269,968	16.6675	$P < .01$
Mos. x Cat.	30	20, 454,317	681,810	.8392	NS
Error	210	170,620,000	812,491		
Total	251	272,240,060			

As the above results show, the "within cell" variation, due to variation among the Components, was tremendous, i.e., it was not possible to partial out any major elements of error variance along any dimensions available, other than among functional categories. One cannot say, for example, that costs are higher in one service than in another or that the cost of particular functional categories varies as a function of the time of year.

In somewhat similar vein, a multi-regression analysis was conducted of individual functional category data, as related to total costs. The attempt was made to see whether, given adequate consistency among ACs, it would be possible to develop a "building block" approach, in which it could be predicted that, in creating a program similar to the ACs, functional element #1 could be expected to contribute a certain proportion to the total cost, etc. In more basic terms, the importance of each functional category (regression weight) in "predicting" the total project cost, would be used to develop estimates of how much cost would be added -- or subtracted -- through the elimination or diminution of any of the functional categories in future programs.

Unfortunately, the great magnitude of diversity among different Components' scores rendered the outcome of this analysis relatively meaningless. Expressive of this lack of systematic relationship among the cost variables is the finding that only three (of the seven) functional categories' costs correlated significantly with total cost, even though total cost was the single sum of functional categories' costs. One would expect a positive correlation of the sum with its parts: the more each of the parts, the greater the sum. Apparently, however, there was no uniform systematic approach to cost allocation across all Components. In the case of a fourth category, there was a non-significant positive correlation, two others related negatively but non-significantly to total cost, while the seventh category bore no (r=.002) relationship to total cost. The three categories correlated with total cost, in order of magnitude, were, respectively, home visits and referrals, needs assessments, and work with family groups. The correlation of .002 was between relatively expensive "time off" and total cost -- a rather surprising lack of relationship.

3.0 COSTS PER NEEDS ASSESSMENTS, HOME VISITS/REFERRALS, AND FAMILY GROUP MEETINGS

Three categories lent themselves to the calculation of cost per unit of service: needs assessments, home visits/referrals, and number of people attending group meetings. Average monthly per unit cost figures were calculated for each of these.

Table 10. Average monthly costs per unit of service, among all Components.

Category	N*	Mean	S.D.	Skew	Min	Range
Needs Assessments	34	$37.42	38.42	1.96	1.50	173.50
Home Visits/ Referrals	36	41.30	33.79	2.28	10.84	174.14
All families**	20	25.26	21.44	2.14	5.56	98.43
AC families	20	48.63	35.93	.98	9.84	120.16

* This number refers to the number of center-months in which the specific activity actually took place.

** These data refer to per family costs when all families attending, rather than AC-only families, are included.

Presented below are the average costs, per center, for each of the service units.

Table 11. Cost per unit service at each center, on the basis of total cost over the monitoring period.

Category	Component Number					
	1	2	3	4	5	6
Needs Assessments	14.24	26.33	25.93	21.74	30.49	27.93
Home Visits/ Referrals	33.71	19.20	49.80	33.59	29.40	23.92
All families	31.49	15.35	70.10	18.15	31.11	145.72
AC families	40.03	59.56	147.20	30.92	47.35	201.77

The range in costs from month-to-month and from center-to-center is great, with considerable skew toward the upper end of the distribution. Given this extreme variability, little credence can be placed in the use of the average as

a single descriptive statistic. The median would be little better in that it reflects only a cost figure which happens to be at the middle frequency in the range of scores -- it would add little to any attempt to project "typical" costs per unit of service, simply because, based upon this demonstration experience, it cannot be said that there is any "typical" cost. Instead, it might be more helpful to deal only with the range in costs associated with delivery of each service, e.g., based upon this demonstration, it can be stated that needs assessments will cost somewhere between $1.50 and $173.50 each! If the costs are looked at not in terms of monthly fluctuations, but over the entire monitoring period, the range in costs is somewhat less extreme in some categories. Thus, inspection of Table 11 shows that the average costs per needs assessment ranged from $14.24 in Component 1 to $30.49 in Component 5; the average cost per referral/ home visit ranged from $19.20 in Component 2 to $49.80 in Component 3; the average cost per family at a family group meeting ranged from $15.35 in Component 2 to $145.72 in Component 6; and the average cost per AC family attending a family group meeting ranged from $30.92 in Component 4 to $201.77 in Component 6. While these ranges do not reflect the routine, marked month-to-month fluctuations in costs, they do provide an estimate which is more stable for purposes of projecting the potential costs of similar programs.

4.0 SUMMARY

Given the extreme variation in scores among the six Components represented in this report, it is impossible to develop any specific generalizations regarding the cost structure of this model program. Granted that only a relatively short time period was involved, nevertheless, there is no discernible trend in the cost data which would suggest the emergency of any inherent stability and/or uniformity. Instead, perhaps unsurprisingly, these highly diverse projects, serving diverse populations in diverse contexts, prioritized their objectives and structured their activities differently, as reflected in the intra-Component allocation of expenditures. Moreover, as might be expected, individual project experience changed markedly from month to month reflecting, no doubt, the emergence of new problems and new priorities. It seems highly doubtful that any valid generalizations could be developed from such a small N, no matter the period of time addressed.

On the other hand, one point should be stressed. The relatively great proportion of costs attributed to "time off" and to "staff training" reflects the nature of the staff. To the extent that it reflects realistic demands common to indigenous personnel, this cost might be regarded as a legitimate investment in the future, or more properly, as a direct service cost to a portion of the catchment area population. Direct program costs are relatively low (33%);

again, however, this is to be expected in a structurally top-heavy organization, in which the relatively higher paid staff is responsible for administrative functions, and in which the actual "people-service" functions are carried out by indigenous personnel who are at the low end of the salary continuum.

CONCLUSIONS

Data analyses notwithstanding, it is still difficult to draw conclusions regarding Advocacy Program outcome. The ACs accomplished much for many people, and effected some permanent community changes; yet ultimate achievement fell far short of initial expectations. Perhaps the most important lesson for everyone concerned related to the amount of time and effort required for such activities. When the program was first discussed at the local level, many simplistic statements were made, e.g., "the reason people don't use the agencies is because the agencies are insensitive," "agency people are unaware of the needs of this community," "all people need is a helping hand and an indication that somebody cares," "we're going to work ourselves out of a job." During the project's 31 months, AC staffs learned that many agency staff members are sensitive to the needs of people, but that they are overworked, understaffed, and often powerless to change policy at the local level. They learned that changes in policy can take years of sustained and well-directed effort. Finally, they learned that many families are so burdened, or so poorly motivated, that kindness alone does not ensure that they will take advantage of what is offered.

The work of the Advocacy Components turned out to be extremely complex. As a result, untrained staff had to learn a variety of skills and perform a series of tasks,

many of which required monumental effort. There were at least four discrete domains of activity involved. First, the task of identifying resources is known to be very demanding. It is generally recognized by social service agencies that the creation of a viable inform and referral service (I & R) takes at least one full year, given the variety of resources to be contacted, the complexity of the information regarding staff functions and eligibility requirements relating to each, and the linkages to be established. Second, door-to-door outreach and needs assessment activities require complex diagnostic skills, as well as information processing capabilities. Third, advocating for changes within agencies, providing necessary documentation as to service gaps, and introduction of legislative changes comprises yet another area of activity. Finally, organization of group events and efforts to educate groups of people to become knowledgeable consumers represents a fourth area of activity.

In retrospect, the decision to work on all fronts simultaneously appears unrealistic, and creates considerable tension and frustration. Perhaps the Component should have chosen between either a case advocacy approach which would have required the setting up of an I & R system and a door-to-door outreach needs assessment and referral effort, or a class advocacy approach which would have required a focus on community education, collaboration with other agencies, and influencing legislation.

Although Advocacy within the PCC/AC context was not really successful as measured against initial expectations, it did demonstrate the following:

- Identification of resources and establishing linkages for the purpose of making sound and responsive referrals is extremely complex and time consuming. It is unlikely that any program, e.g., PCC or Head Start, which assigns only part-time people, who already have other duties, to the creation of an I & R system can really do this successfully. The creation and maintenance of an I & R system cannot be done on "left over" time; it should be the full-time responsibility of a professional staff person, for at least one year.

- Community agencies readily understand the value of Advocacy functions, i.e., outreach, needs assessments, and community education, and would take on such functions if they had the money and staff to do so. Particularly in the rural areas, the health and welfare departments are so grossly understaffed that they simply cannot make regular service visits to families which may live 25-50 miles from the county seat.

- Creation of new resources, as well as changes in agency policy are extremely complex and time consuming. Often changes in legislation, and/or new sources of funding are required. These can be initiated, but not consummated at the local level.

- Child Advocacy demonstrated once again what child protective workers have known for a long time, that there are families which need ongoing ombudsman services and intervention if the children are to avoid being neglected. Despite the rhetoric about having families achieve independence, there are multi-problem families in every community which need life long services if the children are to have even the slimmest chance of avoiding the cycle of poverty.

- Direct services, particularly transportation, seem to be the only way of getting some families to receive services. Either the services, e.g., food, clothing, immunizations, have to be brought to the home or the family has to be given transportation to the resource.

- Preventive health care is far from being a reality, and future demonstrations should be

organized around discovery of the most efficient ways in which to deliver such services as immunizations and well baby check-ups. The referral mechanism seems ineffective and should probably be replaced with mobile health units conducting door-to-door outreach. Moreover, public policy on the right of parents to refuse immunization should be reviewed, as a means to determining whether legislation should be introduced to enforce the immunization of all children.

- While the goal of preventive health care remains unrealized, clinics are either installed, or mechanisms exist for requesting their creation. The situation with regard to housing is absolutely deplorable in that large numbers of families with very young children live in truly inadequate, unhealthy, and dangerous housing. Moreover, no mechanisms exist which would suggest any widespread changes in the next decade.

A program from which so much was learned, and which as a demonstration won the respect of so many agencies, must be viewed as at least partially successful, even if its original objectives remain in large part unmet.